Regulation 28: Prevention of Future Deaths report

Angela Marietta Carpos (died 25 December 2022)

	THIS REPORT IS BEING SENT TO: **1. MiHomecare Cardinal House, Abbeyfield Road, Nottingham, NG7 2SZ**
1	**CORONER** I am: Melanie Sarah Lee Assistant Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 20 January 2023 an investigation was commenced into the death of Angela Marietta Carpos aged 94 years. The investigation concluded at the end of the inquest on 21 December 2023. I made a determination at inquest that Angela died of aspiration pneumonia, the cause of which could not be established.
4	**CIRCUMSTANCES OF THE DEATH** During the evening of 25 December 2022, whilst being attended by carers, Angela collapsed eating dinner. On being alerted to a concern about Angela's breathing, her daughter immediately recognised the seriousness of her condition and called an ambulance. Angela went into cardiac arrest but was successfully resuscitated by paramedics. On arrival at hospital her prognosis was poor as she had suffered hypoxia due to respiratory arrest, secondary to aspiration. She died at the Royal Free Hospital later that evening.
5	**CORONER'S CONCERNS**

	During the course of the inquest, the evidence revealed matters giving rise to concern. In my opinion, there is a risk that future deaths will occur unless action is taken. In the circumstances, it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. In Angela's case, her daughter recognised very quickly that there was a problem and called an ambulance immediately. However, the carers (who knew Angela well, and cared for her with diligence) were unable to recognise aspiration pneumonia and were unclear about whether they had received any training on it, were unclear about what training they do receive, or how often they receive it. The PFD witness was unable to say what qualifications the company's trainers have and did not know the contents of the company's policies.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that your organisation has the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 17 June 2024. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following. • Family of Angela Carpos • HHJ Thomas Teague QC, the Chief Coroner of England & Wales I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make

	representations to me, the coroner, at the time of your response, about the release or the publication of your response.
9	**DATE** 22 April 2024 **SIGNED BY ASSISTANT CORONER**