

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1) Secretary of State for Health and Social Care</p>
1	<p>CORONER</p> <p>I am Alison Mutch, Senior Coroner, for the coroner area of South Manchester</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 17th January 2024 I commenced an investigation into the death of Emilia ALLSOPP. The investigation concluded on the 29th July 2024 and the conclusion was one of Narrative: Died from natural causes exacerbated by the complications of an accidental fall. The medical cause of death was 1a) Lower Respiratory Tract Infection on the background of Left Acetabular fracture II) Dementia, Frailty, Ischaemic heart disease, Congestive cardiac failure.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Emilia Allsopp had dementia, congestive cardiac failure and ischaemic heart disease. She had an accidental fall at the care home where she lived. Initially a fracture was not diagnosed from the x rays. However the following day her pain resulted in her returning to hospital and the fracture being identified. Surgical intervention was deemed inappropriate with her comorbidities. She was treated conservatively. Due to her limited mobility she developed a lower respiratory tract infection when in conjunction with congestive cardiac failure led to her respiratory function being significantly compromised. Her cardiac function was also further compromised by the stress of the fall, fracture and pain. She deteriorated and died at Tameside General Hospital on 15th January 2024.</p>
5	<p>CORONER'S CONCERNS</p>

	<p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>The inquest heard evidence that Mrs Allsopp had struggled at the care home due to it being an unfamiliar environment. Her family had wanted her to remain cared for by them in a familiar home environment. They felt that if they were properly supported, home would be a safer environment for Mrs Allsopp. However Mrs Allsopp moved to the care home due to a lack of suitable community based support meaning that her family could no longer continue to care for her in the community. The inquest was told by her family that it had proved impossible to get the level of support they needed for Mrs Allsopp in the community as her dementia progressed. This created a situation where she was unsafe in her own home and had to move to a new less familiar setting. Effective dementia support for the family would have meant that could have continued to look after her at home.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 1st November 2024. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely [REDACTED] on behalf of the family, Tameside General Hospital who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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 by the Chief Coroner.</p>

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Alison Mutch
HM Senior Coroner



06/09/2024