REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1) The Secretary of State for Health and Social Care** **2) Chief Executive of NHS England**
1	**CORONER** I am Jyoti Gill, HM Assistant Coroner, for the coroner area of Manchester South
2	**CORONER'S LEGAL POWERS** 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.
3	**INVESTIGATION and INQUEST** On 2nd September 2024 an investigation commenced into the death of Winnie Harrop, age 89. The investigation concluded at the end of the inquest on 4th February 2025. The conclusion of the inquest was one of Narrative: Died as a consequence of previously undiagnosed vascular dementia the effects of which were exacerbated by over-sedation in hospital and the contraindicated removal of oxygen prior to discharge. Ms Harrop's death was contributed to by neglect. The medical cause of death was : **1a) Cerebral hypoxia.** **1b) Administration of intravenous lorazepam,** **2) vascular dementia, cerebrovascular disease, fracture of right maxillary sinus, fracture of right orbital floor, ischaemic heart disease, congestive cardiac failure.**
4	**CIRCUMSTANCES OF THE DEATH** On 12 August 2024 around 5 pm Ms Harrop collapsed at the Lakes Care Centre. Ms Harrop was on blood thinning medication and having banged her head was bleeding and so an ambulance was called. Ms Harrop was taken to Tameside General Hospital. At the hospital Ms Harrop showed significant agitation and so was given a sedative intravenously for a CT scan to take place. The CT scan taken showed a fracture of the right orbital floor and right maxillary sinus. On 13 August 2024 at 5:23 am Ms Harrop was discharged back to The Lakes Care Centre. During her recent admission Ms Harrop developed a new oxygen requirement but was discharged to the care home without any oxygen. Care home staff were concerned that Ms Harrop was very drowsy and unresponsive and called the ambulance. Ms Harrop was readmitted to Tameside General Hospital at 11 am on 13 August 2024. Ms Harrop's condition deteriorated, and the decision was made to begin end of life care. Ms Harrop died on 16 August 2024 at Tameside General Hospital.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) There is no clear guidance between health and social care as to when and in what circumstances it is appropriate to send a patient back to a care home.

	Ms Harrop was discharged back to the care home less than 24 hours following her admission despite being overly sedated. The care home was not a nursing home. Ms Harrop's discharge letter failed to refer to the level of sedation provided or that there was a new oxygen requirement.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organization 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 14th May 2025. 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 Chief Coroner and to the following Interested Persons: Ms Harrop's son on behalf of the family, The Lakes Care Centre and Tameside General Hospital who may find it useful or of interest. 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 by the Chief Coroner.
9	**Jyoti Gill** **HM Assistant Coroner**  **19th March 2025**