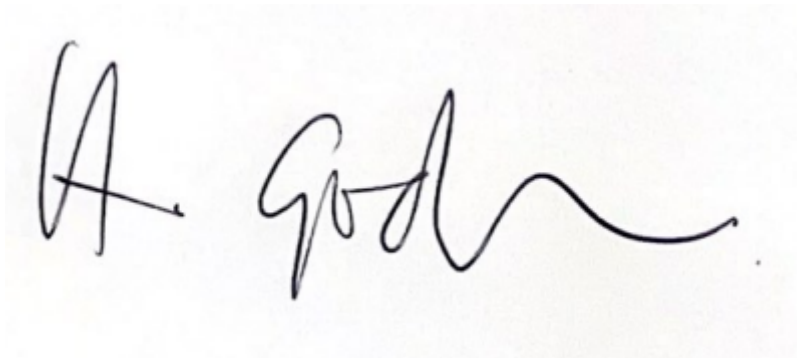
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 The Telecare Services Association**
1	**CORONER** I am Hannah GODFREY, Area Coroner for the coroner area of Berkshire
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. A prevention of future deaths report raises issues and is a recommendation that action should be taken but does not recommend what that action should be. That is a matter for the recipient. It is important to note the case of *R (Dr Siddiqui and Dr Paeprer-Rohricht) v Assistant Coroner for East London.* This case clarifies that the issuing and receipt of a Regulation 28 report entails no more than the coroner bringing some information regarding a public safety concern to the attention of the recipient. The report is not punitive in nature and engages no civil or criminal right or obligation on the part of the recipient, other than the obligation to respond to the report in writing within 56 days.
3	**INVESTIGATION and INQUEST** On 23 April 2024 I commenced an investigation into the death of Mr YZ, aged 64. He had died on 2 March 2024 in his own home (sheltered accommodation). The investigation concluded at the end of the inquest on 10 February 2025. The conclusion of the inquest was a short narrative of 'accident, with a contribution from natural causes'. The medical cause of his death was I(a) Hypovolaemic Shock (b) Compound Fracture Dislocation of right Tibiotalar (Ankle) Joint (c) (d) II Fatty Liver Disease, Huntington's Disease
4	**CIRCUMSTANCES OF THE DEATH** (1) YZ was diagnosed with Huntington's Disease in 2019.

	(2) He died in his own home on 2 March 2024, in the early hours of the morning from extensive blood loss from a traumatic open fracture of the right ankle. (3) He had an emergency careline cord in his home, managed by Appello, which he had activated at 0220 on 2 March. When the operator answered him YZ had spoken initially unintelligibly, and then in response to questions indicated he was ok and did not need help. (4) The call duration was brief. It was logged as an accidental call. (5) YZ did not receive medical assistance and died some time before 0800 the same morning, 2 March 2024. (6) YZ's failure to obtain prompt medical assistance contributed more than minimally to his death.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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) YZ's presentation with Huntingdon's Disease involved altered pain pathways/responses, slurred speech, lack of or reduced insight, tendency to apathy and self-neglect and impaired cognitive processing. (2) These are aspects of presentation that may be present in a wider group of other end-users of careline services (for example those with dementia) and are not limited to end-users with Huntingdon's Disease. (3) I found there was a missed opportunity to obtain life-saving medical assistance that was attributable to YZ's impairments arising from Huntington's Disease. (4) YZ had called for assistance but the operator failed to identify that he had a major injury with significant blood loss. (5) The interaction was very brief, YZ contributing only a few words, and I found key information might have been elicited if YZ had been given more time, asked to repeat his unintelligible opening words, or had been asked open and/or more specific closed questions. (6) I found the operator who answered the call was trained and had followed the protocols that were in place for him at that time. He was not a clinician. His management of the call was in line with the guidelines applicable to his work (Appello Careline Limited guidelines, and the guidelines of the Telecare Services Association, which are followed by most of the careline services industry). (7) After YZ's death Appello Careline Limited quickly and proactively reviewed their procedures and amended their call protocols. At inquest they accepted the offer of the Huntingdon's Disease Association to work with them to identify questioning methods or protocols that might further reduce the risk of similar outcomes in future. (8) The Telecare Services Association was not a recognised interested person in YZ's inquest. (9) I am bringing a risk formally to their attention with this report. The risk is to careline users with similar presentations as YZ if the Telecare Services Association's guidelines continue unamended.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation have 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 May 30, 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 **YZ's family** **The Huntingdon's Disease Association (FAO [redacted], Head of Service)** **Appello Careline Limited (FAO [redacted], legal representative)** 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 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. She may send a copy of this report to any person who she 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	**Dated: 04/04/2025**  **Hannah GODFREY** **Area Coroner for** **Berkshire**