Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Holcroft Grange** **2 Minster Care Group** **3 1st Care 4U**
1	**CORONER** I am Charlotte KEIGHLEY, Assistant Coroner for the coroner area of Cheshire
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 07 October 2024 I commenced an investigation into the death of Margaret Elizabeth DOUGLAS aged 82. The investigation concluded at the end of the inquest on 04 June 2025. The conclusion of the inquest was that Margaret Elizabeth Douglas died as a consequence of naturally occurring disease, contributed to by injuries sustained as a result of recurrent falls. It has not been possible to determine whether, on the balance of probabilities, an acute event occurred in the period immediately prior to her death which contributed to it.
4	**CIRCUMSTANCES OF THE DEATH** On the 1st June 2024, Margaret Elizabeth Douglas had an unwitnessed fall at home, having suffered a minor stroke and was noted to be experiencing increased confusion, slurred speech and difficulties mobilising. Following a period of rehabilitation in Hospital, Elizabeth was admitted to the Heathside Assessment Pathway service to support her recovery and was assessed by the Speech and Language Therapy team as requiring level 2 fluids as she was at risk of aspiration. Whilst at Heathside, Elizabeth suffered two falls, one of which caused a small bleed on her brain which was not identified on imaging at the time. Elizabeth was discharged home with a package of care but was unable to cope because of her risk of falls. On the 22nd August 2024, Elizabeth was moved to Holcroft Grange where her risk of falls was identified as high and she suffered a number of further falls, leading to a decline in her condition, an increase in the size of her subdural haemorrhage, worsening stroke symptoms with her becoming increasingly frail and at increased risk of aspiration. By the 5th September 2024, Holcroft Grange had identified that the were no longer able to meet Elizabeth's needs, considering that she required one to one care, however, they accepted her back without one to one care, following which, she suffered a further fall, causing injury to her face. A condition of Elizabeth's discharge was that one to one care would be provided, which Holcroft Grange outsourced to a care agency. In the days which followed, Elizbeth's condition deteriorated with a worsening of her stroke symptoms and a developing chest infection with a ceiling of care being put in place for her to remain at Holcroft Grange with input from primary care services.

	On the 28th September 2024, it was noted that there had been a further deterioration in Elizabeth's condition, as she was unable to hold her head up and had been unsettled and often screaming. Staff advised that she should be cared for in bed, but no medical advice was sought and consequently the deterioration in her condition was not assessed with no consideration of symptom management or whether she had reached a point whereby she required end of life care. Overnight on the 29th September 2024, Elizabeth was unsettled and the carer who took over her care the following morning was unable to understand what had occurred overnight or communicate successfully to assess Elizabeth's needs. That morning, Elizabeth was provided with a drink, although it has not been possible to say whether at the time, Elizabeth was positioned correctly to avoid her risk of aspiration. Soon afterwards, Elizabeth was laid down, stopped breathing and passed away. Given the ambiguity of the evidence provided at Inquest, it has not been possible to determine whether an acute event occurred at that time which contributed to Elizabeth's 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: (brief summary of matters of concern) i) In the course of the Inquest I heard evidence that by the 5th September 2024, Holcroft Grange had already identified that they were unable to meet Elizabeth's needs, considering that she required one to one care. Despite being aware that they were unable to meet Elizabeth's needs and that they were unable to provide one to one care, Holcroft Grange accepted Elizabeth back into their care, following which she suffered a further fall. Agreeing to provide care for an individual in circumstances where it is known that the level of care that person requires to keep them safe cannot be provided, creates a risk that future deaths could occur as a consequence of inadequate care and supervision. ii) In the course of the Inquest I heard evidence from the individual who was caring for Elizabeth on the morning of her death and in the course of that evidence it became apparent that the carer had little understanding of Elizabeth's needs and had difficulty communicating and understanding information in English. The evidence given by those at Holcroft Grange was that they outsourced the provision of the one to one carers to a company, '1st Care 4 U Ltd' who had been approved for use by their parent company 'Minster Care Group'. At the time the care was provided, it was known by those responsible for sourcing the care, that there were difficulties with Elizabeth's communication and her complex needs. This evidence gives rise to significant concerns in respect of the ability of those providing one to one care to understand an individual's complex needs and their ability to communicate with those who themselves have difficulties with their speech. The concerns were heightened in the context of this case given that Elizabeth was at high risk of aspiration and if carers are unable to understand the complexities of an individual's needs and communicate effectively with them, it poses a risk to their life.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 August 13, 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 [redacted] I have also sent it to **CQC Inquest Reports** 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. 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	**Dated: 18/06/2025**  **Charlotte KEIGHLEY** **Assistant Coroner for** **Cheshire**