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Regulation 28 – Report to Prevent Future Deaths

	This Report is being sent to: [REDACTED], Independent Chair, Safeguarding Adults Board, Chuter Ede Education Centre, Galsworth Road, South Shields NE34 9UG [REDACTED] Strategic Manager, Safeguarding & Professional Practice, Children, Adults & Families, 9-10 Charlotte Terrace, South Shields NE33 4NU
1	**Coroner** I am Terence Carney, Senior Coroner for Gateshead & South Tyneside.
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/regulation/28/made http://www.legislation.gov.uk/uksi/2013/1629/regulation/29/made
3	**Investigation & Inquest** On 17 December 2012 I commenced an investigation into the death of Joan Farran , aged 86. The investigation concluded at the end of the inquest on 26th September 2013. The conclusion of the inquest was :- 1a Bronchopneumonia due to, 1b Chronic Obstructive Pulmonary Disease and Alzheimers Disease A Natural Cause of events contributed to by neglect.
4	**Circumstances of the Death** 1. The deceased resided at [REDACTED] with her adult son and had resided there for a number of years. 2. The deceased suffered from a number of diagnosed and treated co-morbidities including osteo porosis, asthma, emphysema, bronchiateses ischaemic heart disease and diabtes mellitus. 3. She was in receipt of prescribed medications dispensed on a regular and repeated basis. 4. Until July 2012 she was regularly visited by a Community Matron. 5. Her son was her principal and her only carer. There was no community care provision provided for her. 6. On 7th December the son contacted the former COmmunity Matron advising of some deterioration in Mrs. Farran's health He was advised to seek medical assistance and the matron made direct contact with her GP , an appointment being made for the 10th December for a GP home visit. On that day however the appointment was cancelled and no visit was made.

	7. On 17th December the deceased' son visited the home of a family friend and advised her that his mother had died during the evening of the 16th December. Concerned as to what she was being told the friend contacted emergency services and the Police. 8. The Police entered the property [redacted] and found the mother dead in the sitting room amid considerable amount of accummulated rubbish, human and animal waste matter. 9. The son was subsequently arrested on the basis of possible gross negligence , manslaughter and/or neglect. 10. The POlice commenced investigation and determined that the conditions in the house were at least 8 - 10 months old. 11. A Forensic Post Mortem was conducted by [redacted] and a Neuro-Pathologist [redacted] of the Department of Pathology, Aberdeen. 12. [redacted] conclusion as to the cause of death was a bronchopneumonia due to Chronic Obstructive Pulmonary Disease and Alzheimers Disease. 13. The examination of the brain carried out by [redacted] concluded that the deceased' brain showed the histological changes of Alzheimers Disease (stage 5-6) Although this disease had not been formally diagnosed it was of such an advanced stage as to be classified as Alzheimers Disease in his view. More pointedly he observed she was likely to have manifested significant cognitive impairment/dementia. 14. As to the physical cause of death it was observed by [redacted] that the pneumonia was of a type which would if treated have responded to antibiotic treatment. She may not have survived ultimately, her series of comorbidities but this particular illness need not necessarily to have killed her. 15. In view of the acknowledlgement in the course of interview by her son that she had been ill for some days before this incident, it was my conclusion that although death was due to Natural Causes it was contributed to by the neglect to obtain appropriate medical support and treatment. .
5	**<u>Coroners 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 will occur unless action is taken. In the circumstances it I my statutory duty to report to you. The matter of concern are as follows:- 1. In January 2012 the daughter of the deceased, some time estranged from her mother and brother had raised concerns with Social Services at South Tyneside as to the care the mother was receiving from the brother. 2. Social Services visited the mother in her home together with the Community Matron who was currently visiting regularly. 3. The Officers who attended from the Department of Social Services were satisfied on a single visit that everything within the home and the care provision for the deceased was in order and were reassured by the continued visits of the Community Matron Service. 4. They reported to the daughter of the deceased that they found nothing of issue and did not seek to obtain any level of contact with the family. 5. No communication of this visit was made to the General Practitioner. Apparently no issues of concern were investigated or expressed to the General Practitioner at this or at any stage. 6. In March 2012 the practice nurse of the practice to which the deceased was assigned, visited the deceased in her home and again, found nothing untoward in the management and care at that stage. 7. All of these visits appear to have been conducted in the deceased' bedroom and no visits were made to any other part of the house and particularly the living room, dining room, kitchen and back yard. Significantly it is these areas which were found to be excessively cluttered during the investigation by the Police, subsequent to the deceased' death. 8. The Inquest received evidence from an Environmental Health Office who gave evidence that the clutter within the home was at least 8 months old but acknowledged that because this was a criminal investigation, he did not asitwere dig too deep into the material present to identify exact dates as to the packaging and other detritus which was present. 9. The Community Matron was himself unwell in the period March to July 2012 and subsequently from July ceased further visits. No other external services appear to have visited this home between July and December 2012 to determine how the deceased was progressing. 10. There were concerns expressed by the General Practice and in particular by the Pharmacy who

	were dispensing the deceased' repeat prescriptions that there were instances of non-collection of the medication and indeed a review was carried out late in that year as to the nature of the medication the deceased needed. There was no further visit at that stage to the deceased' home however. 11. Having received a communication from the deceased' son, on the 7th December as to his mother's state of health the Community Matron did make direct contact with the practice in order to try and ensure an appointment was made. He was nonetheless of a view that at that juncture there should inf act be some urgent and immediate visit made but the matter was left on the basis only of a home visit to be made on the Monday 10th December. 12. That visit was cancelled and no further contact was made with the deceased or visit made to the home by the practice or any other outside agency. 13. Any visit that was made at that juncture or indeed at any earlier juncture which sought to visit more extensively within the home would have had clearly demonstrated that all was not well in the care and management of the deceased by the son and indeed that the son himself as a carer, was incapable of meeting the needs of his mother and himself was suffering from chronic problems, in all probability alcoholism. 14. The opinion of the NeuroPathologist who examined the deceased' body was of the opinion that the deceased was suffering from established dementia and that that should have been apparent to those who had her care. It was undiagnosed. If the deceased had received even the basic of treatment during the week immediately before her death, there is every reason to believe the deceased' death from a treatable condition would have been avoided. 15. My concern on this occasion is that although there were at least three agencies actively engaged in the care of this lady , or called to review her care during the months preceding her death, there has been a failure to co-ordinate information available to them. 16. There is evidence that they have failed to appreciate or investigate more robustly and objectively circumstances of the deceased' situation ,to be easily put off by the deceased' own presentation in the case of the visit by Social Services early in 2012, reassured that others had apparently raised no issue and in the event were continuing to visit , when ultimately they chose to withdraw those services very soon after. 17. The complaint of the daughter should have at least led to an opportunity to examine the living accommodation more fully and more pointedly to maintain some contact into the future months and not to rely on the result and conclusion of one single visit and in any event to maintain a co-ordinated overview between the Community Matron Services, the GP and Social Services. 18. This incident occurring as it has at or about the same time as Elizabeth and Robert Douthwaite (17th January 2013) highlights the need for a robust and co-ordinate approach between the several agencies working within the Community who may come into contact with individually vulnerable individuals within the community. The active sharing of information and staged reviews are an essential elemtn leading to co-ordinated care strategems. 19. To that end I respectfully suggest the convening of a Safeguarding meeting which would seek to review the issues within highlighted by these and determine the strategems which can best address and assist those working within the Community to better co-ordinate and share knowledge, experience and good practice for the benefit of individual patients.
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 December 2013. 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 & Publication** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons

	and to the Local Safe-Guarding board (where the deceased was under 18). I have also sent it to the who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. 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.
	Date: **{Signature}** **Senior Coroner – Gateshead & South Tyneside**