ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] **Adult Care Commissioners,** Swindon Borough Council, Civic Offices, Clarence House, Euclid Street, Swindon, Wiltshire, SN1 2JH
1	**CORONER** I am David Ridley, senior coroner, for the coronial area of Wiltshire and Swindon
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 30 August 2014 I commenced an investigation into the death of Wendy Bernadine BROWN aged 54. The investigation concluded at the end of the inquest on 11 March 2014 at my court in Salisbury. The conclusion of the inquest was that Wendy took her own life whilst suffering with depression, the cause of death being found as 1a) Compression of the neck structures by a ligature.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of Wendy's death were that Wendy had suffered with depression for a number of years. Towards the end of 1993/1994 she became the full time carer of her baby granddaughter, [redacted] who was severely disabled. On 24 July 2011 [redacted] became 18 and there was a gap of approximately 18 months where Wendy had no support and respite provisions available to her. Care packages were being arranged but they did not appear to come on line until towards the end of 2012. I heard evidence that this had a detrimental effect on her well being. Despite the introduction of care and respite packages at the end of 2012, [redacted] was becoming increasing challenging to look after and shortly before Wendy's death she had indicated to her designated social worker, [redacted] that she would like arrangements to be made as regards [redacted] going into alternative fell time care as she was struggling to cope. I was satisfied with [redacted] evidence that whilst arrangements would take some months up to a year to be finalised due to ensuring the appropriate alternative accommodation was suitable, that transitional arrangements could be implemented in the meantime was explained to Wendy when they spoke on 22 August 2013. There was nothing to cause [redacted] to perceive that Wendy was at risk of self harm let alone that she would kill herself. Following this telephone conversation on 22 August 2013 I found that during late evening into the morning 27/28 August 2013 that Wendy hanged by the neck using a rope suspended through the open loft hatch from a roof joist at her home [redacted] Moredon, Swindon. Her lifeless body was discovered shortly after 9:25 on the morning of the 28 August 2013 by two carers who were making a routine visit.

5 **CORONER'S CONCERNS**

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.

The **MATTERS OF CONCERN** are as follows. –

a) During the course of the Inquest I heard how Swindon Borough Council outsourced their Adult Care to an organisation called SEQOL and that that organisation commenced effective operation in November 2011 with relevant social workers transferring under the Transfer Undertaking Regulations to the new organisation. I heard evidence from the interim Company Secretary at SEQOL and in relation to the delay as regards the implementation of care packages and I was concerned to learn that some 18 months effectively elapsed where Wendy was effectively solely responsible for the care of [redacted] her severely disabled granddaughter, without respite care or care support. I am concerned as regards the adequacy of the measures taken by the commissioners to ensure that relevant Adult Care Public Services are effectively signposted so that the public are aware of available services and more importantly that the funding routes are also highlighted. The system of social adult care is a complicated maze and I have tried to keep this concern as simple as possible. I would be grateful if you could please review the matter having regard to this particular case with a view to establishing whether or not there are any lessons to be learned following the death of Wendy. I understand that no review has been undertaken to date and I am concerned that such delay could place another carer under similar strain and that that scenario could directly contribute to that person's death if they were then to take their own life whilst packages were being arranged.

b) I am also concerned and would be grateful if you could please review the timeliness within which applications both from the funding perspective and service nature are processed under your administration. It concerns me that whilst applications are being processed or even assessments themselves are being undertaken (as I understand it even as part of transition arrangements some organisations will not assess the individual until they are 18) that there is inevitably going to be a gap in support for carers whilst the application is being determined until the care package if approved is implemented. This concerns me in a case where you have an individual such as [redacted] who quite clearly requires an extensive support and care package. I appreciate that instances such as [redacted] are in the extreme but I am concerned that Wendy and [redacted] situation is unlikely to be unique.

c) I am also concerned that there appears to be no ability to appeal against your decision in some areas. CHC funding I was told does have an appeal route however other areas require a fresh application to be made with substantive new information. I would be grateful from the point of ensuring that the right decisions are made as to whether a review could look on this area as well please. The decisions you make impact greatly on carers lives and of course those that they care for.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action and I would ask you to review this particular case in light of my concerns.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 06 May 2014 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] (son). I have also sent it to **Mrs Heather MITCHELL, Chief Executive SEQOL,** Orbital Centre, Thamesdown Drive, Swindon SN25 4AN and **Mr David Behan, Chief Executive Care Quality Commission**, Finsbury Tower, 103–105 Bunhill Row, London, EC1Y 8TG, 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.
9	**12 March 2014**  **SENIOR CORONER**