IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquests Touching the Death of Lillian Rose Robinson
A Regulation Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: **Chief Executive** **SCC**
1	**CORONER** Martin Fleming ADC Surrey
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 20 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 22/1/13 I opened an inquest into the death of **Lillian Rose Robinson** who, at the date of her death was aged 89 years. The inquest was resumed and concluded on 15th and 16th January 2014. I found that the cause of death to be: - 1a. Bronchopneumonia I concluded with a Narrative finding
4	**CIRCUMSTANCES OF THE DEATH** On 31/10/12, Lillian Rose Robinson was admitted to Brockhurst Care Home for intermediary care. On 27/10/12 she was transferred to Upper Halliford nursing home where she was found to have deteriorated and she succumbed and died from bronchopneumonia on 28/12/12.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed a matter that gave rise to concern and which, in my opinion, there is a risk that future deaths could occur by reason thereof unless action is taken. The **MATTER OF CONCERN** is as follows. –

	• Lack of communication between hospital and home re mental capacity assessment • Unqualified medical carers evaluating the appropriateness of capacity in patients with mild/moderate dementia • Poor note taking and continuity of patient care notes At the inquest I heard very helpful evidence from [redacted] I would be obliged if you could confirm that steps have been taken to address these concerns.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that Surrey County Council have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to: • [redacted] • [redacted] • [redacted] • Chief Coroner • Coroners Society for England and Wales
9	**DATED this 26th January 2014**