	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] – Managing Director Telford & Wrekin Borough Council Telford & Wrekin Council, Addenbrooke House, Ironmasters Way, Telford TF3 4NT 2. [redacted] – Assistant Chief Constable West Mercia Constabulary West Mercia Police Head Quarters, Hindlip Hall, PO Box 55, Worcester WR3 8SP 3. [redacted] – South Staffordshire & Shropshire Health Foundation Trust Trust Headquarters, St. George's Hospital, Corporation Street, Stafford ST16 3SR 4. [redacted] – Telford & Wrekin Clinical Commissioning Group Telford and Wrekin CCG, NHS Telford and Wrekin, Halesfield 6, Halesfield, Telford, TF7 4BF
1	**CORONER** I am John Penhale ELLERY, Senior Coroner, for the coroner area of Shropshire, Telford & Wrekin
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 the 13th November 2012 I commenced an investigation into the death of Christine Ann WILLIAMSON aged 62 years. The investigation concluded in an inquest on the 16th December 2013. The conclusion of the inquest was 'The deceased died from a physical assault by her husband who by reason of his lack of mental capacity was unaware of his actions or its consequences. If earlier action had been taken the deceased may have been protected and her death was preventable'. The medical cause of death was: **Ia** Subdural Haematoma following mild blunt head trauma **II** Warfin therapy for recurrent deep vein thrombosis
4	**CIRCUMSTANCES OF THE DEATH** Mrs Williamson was 62 years of age when she died following an assault upon her by her husband who was suffering from advanced onset of Alzheimer's dementia and was unaware of his actions or its consequences. The assault on the 18th October 2012 was the last of 5 recorded assaults between the 6th December 2011 and the 18th October 2012.
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. – (1) A referral and assessment should have been made that the deceased was a Vulnerable Adult at risk from her husband. Such a referral and assessment could have been made before or after April 2012, but most notably on or around the 2nd - 4th April 2012 when the deceased's GP made a direct referral to social services. This should have led to an assessment as a Vulnerable Adult but if not as the victim of domestic violence. (2) Had such an earlier assessment as a Vulnerable Adult been made then discussions would have taken place with all concerned with everyone having significant information sharing it with others. This would have increased the likelihood that preventative measures would have been put in place with the deceased being better or fully informed as to the increased risk she was putting herself in by continuing to live with her husband whose condition was deteriorating. The best illustration of this lack of shared information is that the evidence given at the Inquest when all relevant witnesses were present, should have taken place in a meeting before the situation became critical. (3) An independent domestic homicide review has been undertaken and the author of the report gave evidence at the Inquest including authors or representatives of the relevant individual management reviews. Recommendations were made which I endorse.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 12th February 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 [redacted] [redacted] – Independent Overview Author Service Delivery Manager, Cohesion, Darby House, 5th Floor, Lawn Central, Telford TF3 4LE The Chief Executive – West Midlands Ambulance Service Trust Headquarters, Millennium Point, Waterfront Business Park, Waterfront Way, Brierley Hill, DY5 1LX [redacted] – GP Charlton Medical Practice, Lion Street, Oakengates, Telford TF2 6AQ

	Superintendent [redacted] – For Telford & Wrekin Safeguarding Board Malinsgate Police Station, Malinsgate, Telford, TF3 4HW 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	18th December 2013 John Penhale Ellery