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

The Inquest Touching the Death of Silvia Eileen Taylor
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: Chief Executive – Harmoni South East Home Support Team Leader - Woking Borough Council Forestcare – Bracknell Forest Council
1	**CORONER** Martin Fleming Assistant Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009 paragraph 7, schedule 5 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 14/2/13 I opened the inquest into the death of Silvia Eileen Taylor, who at the date of her death was 81 years old. The inquest was resumed and concluded on 14/7/14. I found that the cause of death to be: 1a – Ischaemic Heart Disease I concluded with a narrative conclusion as follows: On 8/2/13, Silvia Eileen Taylor was found to have died at her home address of ischaemic heart disease. She had earlier activated her emergency pendant for the attendance of the doctor, although several subsequent attempts by the doctors to contact her by telephone were unsuccessful. It is found more likely than not, that earlier medical intervention would not have affected the outcome.

4	**CIRCUMSTANCES OF THE DEATH** On 7/2/13 at 10.06pm Silvia Eileen Taylor activated her care alarm at her home address resulting in an immediate response from the Emergency Response Officer. Mrs Taylor complained of stomach pains and requested a Thamesdoc. The family was contacted soon after and informed that a GP was to attend within 25 minutes. Subsequently Thamesdoc doctors made several unsuccessful attempts to contact Mrs Taylor by phone at her home address. Upon the arrival of the Thamesdoc doctor at her home address at 2.30am her lack of response prompted him to contact the family to request a key to the premises. The family found upon arrival that they could not enter via the front door with the key since it had been bolted internally. The GP left to attend an emergency call after discussing matters with the family. Subsequently the police were called and entry was forced at 4am when Mrs Taylor was found to have died on her bed.
5	**<u>CORONER'S CONCERNS</u>** During the inquest the following concerns arose: - • Although initial reports from Mrs Taylor gave no concern for the need for urgent medical attention, unsuccessful attempts to contact her were not acted upon for several hours. • The difficulties in establishing telephone contact with Mrs Taylor, were not conveyed to the family. I would ask that you consider giving further consideration to the no speech call procedures in relation to after hours support.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that Harmoni, Woking Borough Council and Forestcare has 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** • [redacted] • The Chief Coroner
9	**Signed: Martin Fleming** **DATED this 16-Jul-2014**