Karen Dilks
Senior Coroner for the City of Newcastle Upon Tyne

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: [redacted] Corporate Director of Children, Adult and Families, South Tyneside Council, Town Hall & Civic Offices, Westoe Road, South Shields, Tyne & Wear, NE33 2RL**
1	**CORONER** I am Karen Dilks, Senior Coroner for the City of Newcastle Upon Tyne
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/part/7/made
3	**INVESTIGATION and INQUEST** On 18/12/2014 I commenced an investigation into the death of Olive Nugent, 92 years old, dob 14/6/1922. The investigation concluded at the end of the inquest on 30th March 2015. The medical cause of death was established: 1a. Multiple Contusions Intracerebral Haemorrhage and diffuse Axonal Injury 1b. Head Injury (consistent with a fall) II. Cerebrovascular Disease The conclusion of the inquest was accidental dearth.
4	**CIRCUMSTANCES OF THE DEATH** Olive Nugent lived independently with a care package including carer visits 4 times daily. She was provided with a falls detector device designed to automatically activate in the event of a fall. The device also had a facility for summoning help when required. Wardens were provided with guidance requiring response to device activation within 45 minutes. On the 16th December 2014 Mrs Nugent fell down stairs at her home address. Her device activated at 8.58am. No attendance by a warden occurred until 11.25am. Mrs Nugent had sustained an un-survivable brain injury that led to her death.
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) Mrs Nugent lay critically injured in her home for 2 hours and 27 minutes without assistance or access to medical treatment. (2) Her falls activator device had activated automatically indicating that she had fallen. (3) Her inability to respond verbally to call handlers via the device was a crucial factor in the decision not to prioritise her case. (4) Priority was given to clients whose devices had activated in some cases at a time later than

	Mrs Nugent's but who had been able to verbally respond to call handlers via their devices. (5) The prioritising of response to device activation is entirely subjective and heavily dependent upon (a) staffing levels and (b) the personal practices of individual team leaders. (6) On 16th December 2014 there were insufficient staff to meet the demand for assistance. This contributed to the delayed response to Mrs Nugent's needs. (7) A review of the Guidance to be adopted when responding to device activation was undertaken following Mrs Nugent's death. (8) The Policy Document entitled "Mobile Response Time Targets, Prioritising Mobile Response and Escalation Process", however, reaffirms that prioritisation of response remains a subjective process. A proposed escalation process in the event of demand exceeding the capacity of available staff is dependent upon other agencies whose availability is not guaranteed or the subject of any Memo of Understanding. (9) The provision of Falls Detection Device is intended to ensure timely aid and assistance including medical treatment of injuries if required to vulnerable persons in the event of a fall. (10) Further deaths could potentially occur in the future; particularly in cases of persons injured and unable to respond verbally to call handlers. (11) Review of the Guidance and Policy Document and staffing levels is necessary to reduce this risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [redacted] 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 4th June 2015. 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 Martin Swales, Chief Executive, South Tyneside Council, Town Hall & Civic Offices, Westoe Road, South Shields, Tyne & Wear, NE33 2RL. 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	Dated 31 March 2015 Signature _____ Senior Coroner for the City of Newcastle Upon Tyne