REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. **[redacted] Director of Adults Social Care, Cumbria Social Services, Cumbria County Council, 15 Portland Square, Carlisle, Cumbria CA1 1QQ**
2. **[redacted], Owner and Manager, Green Lane House, Greenhill,Brampton, Cumbria. CA8 1SU**

CORONER

I am Robert Chapman, Assistant Coroner, for the Coroner Area The County of Cumbria

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.

INVESTIGATION and INQUEST

On 19th September 2014 I commenced an investigation into the death of Meryl Parry, aged 80. The investigation concluded at the end of the Inquest on 6th July 2015. The conclusion of the inquest was:

The Cause of death was:

1.a. Plastic bag asphyxia

The Conclusion of the Coroner was:

Mrs Parry was unlawfully killed

CIRCUMSTANCES OF THE DEATH

Mrs Parry had suffered from memory loss from about 2006 and in 2012 she was diagnosed as suffering from Alzheimer's disease. She lived with her husband, [redacted]
[redacted]

Her abilities declined and this coincided with a substantial downturn in Mrs Parry's own health. In August 2014 [redacted] after discussion with Mrs Parry's social worker and her GP, had decided that Mrs Parry should be accommodated in a residential home. He had spent a considerable amount of time looking for the home that he felt would be best able to accommodate his wife. One of the features of her disease was that Mrs Parry tended to wander away from home.

It was agreed that on 1st September 2014 Mrs Parry would be assessed by [redacted] at the Green Lane House, Residential Home, and that she would stay there for at least respite care whilst [redacted] had hospital treatment. Mrs Parry was admitted to Green Land House on the 1st September 2014.

On the afternoon of 1st September 2014 Mrs Parry managed to leave Green Lane House unobserved, and was found walking into Brampton. She was returned to Green Lane House and a decision was made by [redacted] that it was not going to be possible to safely accommodate Mrs Parry. [redacted] telephoned [redacted] who was too tired to come to collect her, so she was fed, bathed, and put into her night clothes and returned to her home address. This occurred about 8pm on 1st September.

[redacted] telephoned a number of residential homes, and no one was able to take his wife that night. He did not believe that Mrs Parry would be happy and able to survive

living in a secure dementia unit. He was suffering from heightened tension, anxiety and stress, and he killed Mrs Parry.

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) There appears to be no system in place whereby the managers of a residential home are required to seek advice from Social Services before discharging a resident
(2) There is therefore a serious risk that there are no appropriate arrangements in place to ensure the safety and welfare of the resident after discharge.
(3) The system for seeking advice from Social Services should apply irrespective of whether Social Services had placed the resident at the home or whether the placement had been a private one. In the latter case it is likely that a social worker will have been aware of, or had some involvement in, the placement.

ACTION SHOULD BE TAKEN:

Cumbria County Council
Social Services should provide general guidance to residential homes in which it is required that if a residential home is considering discharging a resident then before they do so they should seek advice from Social Services so that Social Services can be satisfied that there are appropriate arrangements in place for the safety and wellbeing of the resident after discharge, and the appropriate time for that discharge. This would apply if Social Services had been responsible for placing the resident within the residential home, and also if they had been placed privately without any Social Services direct involvement.

Green Lane House
That you should provide to Cumbria Social Services confirmation that your procedures have been changed so that you follow the guidance set out above. You should send me a copy of the confirmation that you send to Cumbria Social Services.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 2nd September 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:
[redacted] of Arnison Heelis solicitors, as Executors to Mrs Parry's will
[redacted]
[redacted]

I have also sent it to the following who may find it useful or of interest:
The Cumbria Constabulary ([redacted]
[redacted]
Diane Wood Chief Executive of Cumbria County Council
[redacted] Legal Department, Cumbria County Council

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.

8th July 2015	**Robert Chapman**	**[SIGNED BY CORONER]**