## **REGULATION 28: REPORT TO PREVENT FUTURE DEATHS**

## **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS** THIS REPORT IS BEING SENT TO: Kingslev Care Home Silk Cutters House, School Road, Lowestoft, Suffolk, NR33 9NA Manager of Timperley Care Home 53D Mainwood Road, Timperley, Cheshire, WALS 7JW. 1 CORONER I am Joanne Kearsley Area Coroner for Manchester South **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 the 18th April 2016 I concluded the Inquest into the death of Marjorie Wood date of birth 22.08.1918 who died on the 02.12.2015. The cause of death was 1a)Bronchopneumonia 2) Advanced Alzheimer's Dementia and CVA I recorded a natural causes conclusion. CIRCUMSTANCES OF THE DEATH The Court heard evidence that the deceased had a history of dementia and was residing at Timperley Care Home. She had been found deceased at the care home on the 02.12.2015. The death was reported to HM Coroner as she was said to be subject to a Deprivation of Liberty Safeguarding Application (DOLS). An Inquest was opened and evidence requested from Timperley Care Home. Several requests for evidence were ignored by the Care Home so a full hearing had to take place. At the Inquest the Manager was unable to confirm whether in fact the deceased was subject to a DOLS application as Timperley had no information from the Local Authority as to whether this had been authorised. No efforts had been made to contact the Local Authority to obtain this information by the Care Home.

	They did not know whether the deceased was or was not subject to a DOLS or whether this made any difference to the care and treatment she required.
	A DOLS application had in fact been in place since August 2015.
5	CORONER'S CONCERNS
	The concerns noted by the Court during the course of the Inquest are as follows:
	Whilst there was no evidence in this case that the lack of clarity or knowledge in this particular case made a difference to the deceased, it is important that there is a full understanding of the legal status of an individual who is in a care home as this may impact on their care and treatment needs.
6	ACTION SHOULD BE TAKEN
	In my opinion action should be taken to prevent future deaths and I believe you 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 20.06.2016. 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 namely, the family of Mrs Wood
	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	25.04.2016 Joanne Kearsley Area Coroner