	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Legal Department Durham County Council** **2. Capsticks representatives of Haven Day Care Centre**
1	**CORONER** I am Oliver R Longstaff assistant coroner, for the coroner area of County Durham and Darlington
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. (see attached sheet)
3	**INVESTIGATION and INQUEST** On 1st of June 2017 I commenced an investigation into the death of Stanley Langdon, aged 93 years. The investigation concluded at the end of the inquest on 17th April 2018. The conclusion of the inquest was :- Medical cause of death 1a Bronchopneumonia 1b Immobility following operatively repaired periprosthetic left femoral fracture. Conclusion - Accident
4	**CIRCUMSTANCES OF THE DEATH** Stanley Langdon died at the Dipton Manor Care Home on 21st May 2017 from complications arising from a periprosthetic left femoral fracture sustained on 6th March 2017 when he was being assisted by carers to climb the steps onto a minibus. Had he been mobilised on to the minibus in a wheelchair via the available hydraulic lift he would not have sustained that fracture.
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) On 6th March 2017, the deceased was in the care of the Haven Day Care Centre, who were providing respite care services to the deceased that were being funded by Durham County Council. (2) Prior to the commencement of services being provided to the deceased by the Haven Day Care Centre, no care plan or assessment of the deceased's needs had been received from Durham County Council by the Haven Day Care Centre. (3) The Haven Day Care Centre began to provide services to the deceased on 9th January 2017, without having any adequate care plan or assessment of the deceased's needs in place. (4) The inquest was told in evidence that Durham County Council had systems in place to ensure that service providers such as the Haven Day Care Centre would not be

	authorised to provide services unless and until they had received a care plan and assessment of needs in relation to any specific service user. (5) The inquest was also told in evidence that the systems referred to in (4) were not being applied consistently, and service providers (specifically Haven Day Care Centre) were still commencing the provision of services to service users without receiving care plans and assessments of need for particular service users. (6) The care plan that was put in place for the deceased at the Haven Day Care Centre after services had begun to be provided to him was not based on all the information that was or should have been available, and that the said care plan had not been discussed and agreed with the deceased's family (it being noted that the deceased was a dementia sufferer heavily reliant on his family for care from day to day) (7) It appears to me that there is a risk that similar situations as that applying to the deceased may arise in the future, whereby the Haven Day Care Centre may begin to provide services to a service user without having been provided with relevant information in the form of a care plan and needs assessment from Durham County Council, and without having in place their own care plan and needs assessment based on complete information and adequate discussion with a service user's family (in circumstances where the service user was heavily reliant on the family for care from day to day). (8) In my opinion the above risk itself creates a risk that accidents similar to that which befell the deceased on 6th March 2017 may occur in the future, and that there is a risk that future similar incidents may result in the death of a service user in circumstances similar to the deceased's death.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 14th June 2018. 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 1. Browells Solicitors representatives of the family. 2. Ward Hadaway representatives of NEAS 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	**19th April 2018** **Oliver R Longstaff** **HM Assistant Coroner, County Durham and Darlington**