## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>1. Birmingham City Council<br><br>2. Care Quality Commission |
| 1 | **CORONER**<br><br>I am Emma Brown, area coroner, for the coroner area of Birmingham and Solihull. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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. |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 17th April 2015 I commenced an investigation into the death of Eliza Simpson. The investigation concluded at the end of the inquest on 19th August 2015. The conclusion of the inquest was that the medical cause of death was ischaemic heart disease due to coronary artery disease and the conclusion as to the death was Accidental Death. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Mrs Simpson left her residence Roseneath Care Home, [redacted] unobserved on the 2nd April 2015. It is not known how Mrs. Simpson was able to leave as all doors are locked on a magnetic locking system that was fully operational at the time. Mrs Simpson ought to have been being closely monitored and should not have been able to leave the home unobserved due to the effects of dementia, she ought also to have been the subject of a Deprivation of Liberty Safeguarding order ('DOLS') and although one had previously been put in place when it expired no application to renew it was made by the management of the Roseneath Care Home. Consequently it is my conclusion that there was a failure to adequately observe Mrs Simpson and to provide appropriate, legal, safeguards to ensure she did not leave the Care Home unaccompanied. Once her absence was discovered and reported to the police, the police conducted a diligent search for Mrs Simpson but she was not located until the 6th April 2015 when her recently deceased body was found by a member of the public at a local allotment.<br><br>The Police's search for Mrs. Simpson was hampered by the fact that no CCTV cameras were in place at the entrances to the Roseneath Care Home so it was not possible to identify the precise time she left the property and the direction she went in.<br><br>It could not be concluded that the fact Mrs Simpson was able to leave the Care Home was causative of her death. |
| 5 | **CORONER'S CONCERNS**<br><br>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. |

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| | The **MATTERS OF CONCERN** are as follows. –<br><br>(1) The Roseneath Care Home appeared to have no system for ensuring that when deprivation of liberty safeguarding orders expired the client was re-assessed to determine whether the need for an order persisted and, where appropriate, seeking further order. In this case the home would have had no legal authority to hold Mrs. Simpson if she had been detected attempting to leave the premises on the 2nd April 2015. The very act of assessing Mrs. Simpson and renewing an application would have served to enforce to the Care Home and its staff the risk of her absconding and may have resulted in closer observation. Although the Roseneath Care Home has now closed if such a system is not standard in Care Homes this issue may arise elsewhere.<br>(2) The absence of CCTV hampered the Police investigation, although this is unlikely to have contributed to Mrs. Simpson's death this may not always be the case and did mean that a very vulnerable member of society was left wondering around on her own when she might otherwise have been found with the aid of CCTV footage. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. A review is required of the current requirements and/or guidelines for CCTV monitoring of exits in care homes and the systems operated by Care Homes to keep track of the expiry date of DOLS orders so as to make further applications where necessary. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by the 15th October 2015. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: Acting Inspector Ahmed of the West Midlands Police, [redacted] the deceased's daughter and [redacted] the deceased's son.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **27th August 2015** **Signature:**  |