	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Care Quality Commission, Devon Partnership Trust, Plymouth Safeguarding Adult Partnership**
1	**CORONER** I am Ian Michael Arrow, Senior Coroner for Plymouth Torbay and South Devon
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** An Inquest was opened on 21 June 2019 and heard on 24 March 2021 in the Coroners area for Plymouth, Torbay and South Devon. Name of deceased Glenn Macmartin. Medical Cause of Death 1(a) Bronchopneumonia (treated) 1(b) Immobilization 1(c) Old Head Injury II
4	**CIRCUMSTANCES OF THE DEATH** The deceased suffered from Bipolar Disorder and Acquired Brain Injury. He required specific care and accommodation. The deceased was involved in a serious road traffic collision at the age of 16, which caused a brain injury. On the balance of probability he subsequently developed Bipolar Affective Disorder and Frontal Lobe Syndrome. He suffered latterly from deteriorating mobility and memory. He was admitted to a Mental Health Hospital. He was made the subject of a Community Treatment Order. Upon his release from the Mental Health Hospital he was to be accommodated. Arrangements were made by a state funded provider for him to be accommodated in a small privately owned care home which had been recently established. Concerns were raised about the care home. In particular, the note keeping for residents appeared to be sub optimal. The deceased was admitted to hospital. The care home closed. The deceased died in hospital on 1 April 2019.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) The deceased was accommodated in a Care Home that was subsequently formally closed due to poor service. The selection of the accommodation was made without a physical inspection of its suitability for the deceased by the organisation with responsibility for providing the accommodation before the deceased took up residence.

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. Please review the selection and monitoring of care home provision and care given by private care home providers who are funded by Devon Partnership Trust. Please review what actions are taken when care homes are closed to ensure lessons are learnt from such closures. Please indicate when a report on such a review may be forthcoming.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 2 July 2021. 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 to the family . 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 **7 May 2021** Signature_____ **I M ARROW** **Senior Coroner** **Plymouth, Torbay and South Devon**