REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Head of Adult Social Care Leeds City Council Merrion House, 110 Merrion Way, Woodhouse Lane, Leeds. LS2 8DT.
1	**CORONER** Lorraine Harris, Assistant Coroner for the coroner area of West Yorkshire (Eastern) at Wakefield. (Cover)
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.
3	**INVESTIGATION and INQUEST** On 23 October 2020 I commenced an investigation into the death of Netlyn Mae ROBINSON, age 78. The investigation concluded at the end of the inquest on 22 June 2021. The conclusion of the inquest was: Narrative: Netlyn Mae ROBINSON had been a resident in Hillcrest Care Home since April 2020 while her house was renovated to accommodate her reduced mobility. On 2 October 2020 she returned home to [redacted] Gilpin Terrace, Upper Wortley, with a care plan in place for three daily visits providing assistance general living. Mrs Robinson did not have a history of problems with eating. She had assistance to help prepare her evening meal on 3 October 2020. She was discovered the following morning still at the dining table having choked on her food. MCCD: 1a Choking on food, 2 Ischaemic and Hypertensive Heart Disease
4	**CIRCUMSTANCES OF THE DEATH** Mrs Robinson had capacity. In December 2019 Mrs Robinson had been admitted to hospital and then conveyed to a mental health care facility (The Mount). She was discharged from The Mount on 15 April 2020 in to a care home while appropriate alterations were made to her home to accommodate her mobility issues. Social care were responsible for the alterations which included moving her bedroom downstairs and providing a commode to avoid her having to climb

	stairs to the bathroom. She had a care package in place for carers to visit three times a day for general living assistance. There were no reports or records with regard to any eating difficulties. When she returned home on 2 October 2020 she was met by a social worker.
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 could 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) In evidence it became apparent that there was no falls pendant or alarm provided on Mrs Robinson's return home despite her previously having one when last at home. There appeared to be no process in place to check whether there was a fully operational alarm system in place when needed. Further that Mrs Robinson was not consulted about the lack of an alarm until she had arrived home, thus no process in place to provide a person with relevant information in order that they are able to decide whether or not to return to their home address without any form of alarm. (2) The telephone line was not connected. There appeared to be no process in place to check that telephones are working and that a vulnerable person has the ability to call for assistance (emergency or otherwise) or communicate with friends/relatives. (3) With a lack of alarm or phone line there was still no risk assessment as to how an alarm could be raised. (4) The heating was not working/turned on and again there appeared to be no process in place to check premises had heating, running water or smoke alarms and therefore was fit and safe for a vulnerable person to return to. (5) The social worker stated he had been trained on the job to risk assess. He had never been shown a check list for the numerous issues that need to be checked prior to allowing a vulnerable person to be returned home. This included checking on current medical needs (although Mrs Robinson did not have any reported issue regarding eating/chewing/swallowing the question was not asked by the social worker ensuring her safe return home) (6) It was acknowledged that the home was owned by Mrs Robinson however there appeared no processes in place to outline what social services would and would not do to ensure that Mrs Robinson's premises were suitable.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation 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 12 August 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 following Interested Persons: • [redacted] (Daughter) • [redacted] (Nephew) • [redacted] (Niece) A copy has also been sent to [redacted] from Leeds City Council who was present taking a noting brief. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**DATE** **SIGNED BY CORONER** **23 June 2021** **Lorraine Harris, Assistant Coroner**