	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Devon County Council, Adult Social Care**
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** **Joan Mary PRESCOTT** Following an Inquest opened on the 22 May 2020 and an inquest hearing at HM Coroner's Court, Plymouth on the 25 June 2021 heard before Ian Michael Arrow, in the coroner's area for Plymouth, Torbay and South Devon.
4	**CIRCUMSTANCES OF THE DEATH** The deceased lived alone. On the balance of probability, she was not compliant with her medication. On the balance of probability she neglected herself. She deteriorated. She was conveyed to hospital where she sadly died on 9th May 2020. NATURAL CAUSES
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] Safeguarding Consideration at the time of the visit – There was no reference in the recordings to a discussion on safeguarding being considered. Again, on interviewing the social workers they felt there was a need for GP involvement and for an admission, not safeguarding at that stage (missed opportunity). The social workers formed an opinion that the initial focus was not on the state of the property, which was a known situation, but on the immediate presenting potential physical and mental health needs, hence their plan to recommend to re-contact GP for involvement. There is a clear recording of this reflection and decision in notes following visit. Following the welfare visit the GP was made aware (24/04/2020) of findings via the Duty Worker.

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 action advised by [redacted]
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Wednesday 25 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: GP Devon Partnership NHS Trust Devon and Cornwall Police 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 Wednesday 30th June 2021 Signature_____