**ANNEX A**

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

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

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**Ms [redacted], Care Quality Commission,** |
| 1 | **CORONER**<br><br>I am Andrew Cox, the Acting Senior Coroner for the coroner area of Cornwall and the Isles of Scilly. |
| 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>On 14/10/20, I concluded an inquest into the death of Avis Mary Addison who died on 22/2/17.<br>.<br>The medical cause of death was recorded as:<br>1a) Suffocation<br>1b)<br>1c)<br>II) Alzheimer's Dementia, Frailty of Old Age and Multiple Blunt Force Injuries<br><br>I recorded a Conclusion of Unlawful Killing. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>The tragic circumstances behind Mrs Addison's murder at the hands of her late husband have been the subject of a joint Safeguarding/Domestic Homicide Review (DHR 7.) A copy of the updated DHR overview report (dated 11/19) is attached.<br><br>When I first reviewed this matter, I was concerned to ascertain whether there was sufficient reason to resume the inquest after its adjournment to allow the criminal prosecution to take place. At a hearing with the Interested Persons (IPs) in April 2020, I concluded there was sufficient reason and identified the following central issues:<br><br>a) Was there a failure or delay in recognising the potential for domestic abuse and/or violence?<br>b) Has the need for a domestic abuse/violence policy been circulated to all GP practices in the coroner area and has this been brought to the attention of practitioners? The views of NHS Kernow are required.<br>c) Has the need for domestic abuse/violence policies in primary care nationally been considered and, if appropriate, actioned? The views of NHS England are required.<br>d) Has there been a failure or delay in considering whether to conduct a Mental Capacity Act examination of Mrs Addison? The views of the GP and Social Worker are required.<br>e) Is there clarity in the process for raising a safeguarding concern? The view of |

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| | Adult Social Care is required.<br>f) Are Social Workers aware of the potential application of the provisions contained within the Care Act 2014? The view of Adult Social Care is required.<br><br>It is in relation to points b) and c) that I write to CQC. Of particular concern was that these issues had been recurring themes in earlier DHRs giving rise to the worry that lessons had not been learned from previous experiences.<br><br>Further evidence addressing those issues was obtained and I enclose copies of the letters I received from Mrs [redacted], Chief Officer for KCCG, dated 23/4/20 and Mrs [redacted], Assistant Director for Quality and Safeguarding, from NHS England (South-West) dated 9/6/20.<br><br>You will see the steps taken by NHS Kernow to ensure GP practices in Cornwall and the Isles of Scilly have appropriate Domestic Violence policies and Safeguarding Leads in place. You will also see that national recommendations were not able to be acted upon. |
| 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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>I am concerned to ensure that the lessons from this and previous tragedies are learned and robust checks are made to prevent future deaths from happening.<br><br>Given CQC is the agency responsible for inspection of GP practices, one way to ensure GP practices have domestic violence and safeguarding policies in place, and to ensure that all staff have received training on their contents, is to include checks in this regard as part of your inspection regime. It is, of course, entirely possible that this is already part of the process.<br><br>Another matter that you may feel would be beneficial to inspect is whether practices have in place some form of 'early warning system' where, for example, prescriptions are not collected or appointments are cancelled without good reason (eg by a controlling partner.)<br><br>I accept this may be more difficult to do in non-prescribing practices but with clear guidance I would hope that it may still be possible to achieve. |
| 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. |
| 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 14 December. 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: [redacted], KCCG, NHS England (South West), Adult Social Care, Adult Safeguarding. |

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| | 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 | **[DATE]** **[SIGNED BY CORONER]**<br><br>**14/10/20** |