Miriam Joyce Smith-Cox deceased

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **[redacted] – [redacted]Education, Health and Social Care, Cornwall Council**
1	**CORONER** I am the Senior for the coroner area of Cornwall
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** After presiding over the inquest into the death of Ms Miriam Joyce Smith-Cox at 12.00 noon on 20th July 2015 at Truro Municipal Buildings, Truro
4	**CIRCUMSTANCES OF THE DEATH** Miriam Smith-Cox was found dead at around 14.10 pm on the 4th March 2015 at [redacted], Newlyn, Penzance. She was found lying on her back on the stairs leading to the front door with a significant head injury. She was last known to be alive at around 17.00 pm on 3rd of March 2015. She was a large lady (BMI 55) who lived in squalid conditions. She was known to Social Service and the Housing Association and her GP to self-neglect. She suffered from mild learning difficulties although not formally diagnosed. On that day her cat was to be taken to the vet/foster placement prior to Ms Smith-Cox being placed in a respite/rehabilitation placement in a Residential Home while her flat was cleaned and decluttered. She had been referred to the Pluss Work Choice Programme in August 2014 by the Disability Employment Advisor for the Job Centre Plus having been on benefits for many years. She was assessed as having psycho/social issues at that time which prevented her from accessing

	the work place. During the assessment by Pluss Work Choice, Programme safeguarding concerns were raised by the Employment Team manager to Social Services in December 2014 with regards to the suitability and state of her accommodation which was not acknowledged or acted upon for unknown reasons. It was not clear the extent that neglect/self-neglect played a part in the death as the reason for her fall down the stairs was not established the cause of death was due to the injuries consistent with her fall down stairs.
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. – That [redacted], [redacted] with Pluss Work Choice Programme Cornwall raised a safeguarding concern about the suitability of Ms Smith-Cox accommodation and living conditions in December 2014 (see attached letter to [redacted] dated 4.12.14 and report) which [redacted] gave evidence she did not receive or act upon. [redacted] was a key stakeholder in the support of Ms Smith-Cox. Ms Smith-Cox fell down the stairs for unknown reason as raised as a concern by [redacted] and this fall led to her death.
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. To review your safeguarding adult procedures (in particular how concerns are logged, processed and dealt with) and provide me with reassurance that lessons have been learnt with the view to avoiding future deaths.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 13 September 2015. 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 person [redacted] I have also sent it to Devon and Cornwall Police Adult Safeguarding Team Persons [redacted] with Pluss Work Choice, Programme, Cornwall, [redacted] the Case Co-ordinator with Cornwall Council and to the LOCAL ADULT SAFEGUARDING BOARD who may find it useful or of interest. 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	**24.07.15** **Dr Elizabeth Emma Carlyon, Senior Coroner for Cornwall**