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:** **1. [redacted] Chair**
1	**CORONER** I am Mr. T. G. Moore, Assistant Coroner, for the area of Avon
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 2nd August 2011 I commenced an investigation into the death of **Ann Margaret SPEARING**, Aged **62**. The investigation concluded at the end of the inquest on 30th July 2013. The conclusion of the inquest was "Ann Spearing died of pneumonia and malnutrition contributed to in part by self- neglect following a bereavement, a move to a new home, continuing anxiety and dependence issues.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances are, a history of learning difficulties, bereavement and dependency issues. Living in assisted accommodation with very caring staff. Reviewed on three occasions by the Mental Health Service but found not to be suffering from a mental illness, seen by hospital staff when clearly malnourished but found not to have a medical condition. Referred to and reviewed by the eating disorders unit but assessed as not having an eating disorder.
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 concerns are that despite the involvement of all the relevant organisations this lady was able to precipitate her death by starving herself over a period of many months leading her GP to predict her death some months in advance. It appears that each of the relevant organisations had drawn their criteria in such a way as to exclude this lady from their care. She was always someone else's problem. There needs to be some method of providing funding in such cases rather than spending time and money passing the person from one agency to another without any positive curative action being taken.
6	**ACTION SHOULD BE TAKEN** 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** You are under a duty to respond to this report within 56 days of the date of this report,

	namely by 14th October 2013. 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] [and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)]. I have also sent it to [NAMED PERSON] 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	**[DATE]** 20 Aug 2013. **[SIGNED BY CORONER]**