	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Cornwall & Isles of Scilly Safeguarding Adults Board, 1st Floor, East Wing, New County Hall, Treyew Road, Truro, TR1 3AY**
1	**CORONER** I am Dr Elizabeth Emma Carlyon, Senior Coroner 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** The investigation into the death of Anne Shirley Scott was opened on the 2nd October 2014. It was concluded by way of an inquest on the 3rd March 2015. The verdict was accidental death and the causes of death were 1(a) Renal Failure 1(b) Rhabdomyolysis (clinically) & 1(c) Un-witnessed fall.
4	**CIRCUMSTANCES OF THE DEATH** Anne Scott had an unwitnessed fall over night and was found by her carer in the morning of the 29th August 2014 crouched over in a cupboard at her home address, [redacted] She was admitted to the Royal Cornwall Hospital, Treliske, Truro and diagnosed with acute kidney injury secondary to Rhabdomyolysis. She had significant bruising to her legs. Despite being started on haemodialysis, her renal function deteriorated and she was discharged on 16th September to her daughter's house for end of life care and she died on 19th September 2014. Mrs Scott was prone to urinary tract infections (UTI's) during which she became confused and vulnerable to falls. A "Teleheath" monitoring device was put in place; however, the care provider did not appreciate the information provided by the device and act on it.
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 these circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – 1. That special health monitoring devices are being used to monitor health conditions in patients who are receiving care in the community. However the care providers do not have the necessary training to be able to understand how the device operates, the information it provides and appropriate action to take, dependent on the information from the device, in conjunction with other observations. At the inquest we heard that this matter was referred to the Safeguarding Adults Board and some learning points had been identified for the care providers. In particular, it was known that Mrs Scott was prone to urinary tract infections and whilst suffering from these infections Mrs Scott was known to become confused. A special health monitoring device (Telehealth) was in place. The care provider failed to identify the urinary tract infection prior to admission. These were addressed in the Adult Safeguarding Board

	learning points. [redacted] (Social Worker) and [redacted] (Care Provider Representative) confirmed changes were being considered but could not confirm if recommendations were being implemented. Both the representative of the Safeguarding Adults Board and the care provider consider that a Regulation 28 report would assist in embedding the Safeguarding Adults Board recommendations which had countywide implications.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe the Cornwall and Isles of Scilly Safeguarding Adults Board has the power to take such action. To consider recommendations outlined by the local Safeguarding Adults Board in this case are considered countywide in particular with the training and use of Telehealth.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Tuesday 8 March 2016. I, the coroner, may extend the period. Your response must contain details of actions 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] (daughter) 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	**12 January 2016** **Dr E Carlyon:** Elizabeth Emma Carlyon