## **ANNEX A**

## 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:
	<ol> <li>Joanne Roney, Chief Executive, Wakefield MDC, County Hall, Bond Street, Wakefield, WF1 2QW.</li> </ol>
	2. Independent Chair of Wakefield District Safeguarding Adults Board, Grange View, Annie Street, Outwood, Wakefield, WF1 2PW.
1	CORONER
	I am Melanie Jane Williamson, assistant coroner, for the coroner area of West Yorkshire (eastern district)
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
	On the 15 <sup>th</sup> August 2012 I commenced an investigation into the death of Irene Scholey, aged 73 years. The investigation concluded at the end of the inquest on the 6 <sup>th</sup> November 2015. The conclusion of the inquest was a narrative conclusion (see attached), and the medical cause of death was:-
	1(a) Pneumonia and empyema
4	CIRCUMSTANCES OF THE DEATH
	See attached Narrative Conclusion.
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. –
	(1) Mrs Irene Scholey was an elderly and vulnerable 73 year old lady.
	(2) In around 2010 Mrs Scholey commenced residing permanently with two of her daughters.
	(3) The household was dysfunctional, was an inappropriate environment for Irene Scholey to be living in, and was a risk to her physical and emotional wellbeing.

	(4) A safeguarding alert was raised in respect of Mrs Scholey in April/May 2012.
	(5) Her wellbeing would have been safeguarded had all relevant agencies been able to access, and to share, information relating to the home environment in which Mrs Scholey was living.
	(6) The Multi Agency Safeguarding Hub ("MASH") in Wakefield is a gold standard service providing agencies with access to/sharing of information concerning safeguarding issues in respect of children.
	(7) MASH could be extended to include the elderly (65 years and above) and vulnerable adults.
	(8) There are many adults in a similar position to that of Irene Scholey in this District for whom MASH would be of enormous benefit.
6	ACTION SHOULD BE TAKEN
	In my opinion action should be taken to prevent future deaths and I believe Wakefield MDC has 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 8 <sup>th</sup> January 2016. 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 :-
	(1) (2)
	I have also sent my report to the following persons who may find it useful or of interest:-
	(1) Admin Support, Fieldhead Hospital (2) Head of Legal Services, Pinderfields Hospital (3) Viv Segerius-Allick, West Yorkshire 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	13 <sup>th</sup> November 2015
	MELANIE J WILLIAMSON Assistant Coroner
	West Yorkshire (eastern district)