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:** **1. Mr [redacted], Corporate Director, Adults, Health and Communities, Wakefield**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner, for the Coroner area of West Yorkshire (Eastern).
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 09/06/20, I commenced an investigation into the death of June Mavis Winterbottom, aged 90. The investigation concluded at the end of the Inquest on 23.09.20. The conclusion of the Inquest was a narrative conclusion based upon a medical cause of death of: Ia Urosepsis II Type 2 diabetes.
4	**CIRCUMSTANCES OF THE DEATH** June Mavis Winterbottom, aged 90, lived alone in sheltered accommodation. On 02/6/20, a relative contacted Adult Social Care at 12:20 hours to report she had been lying in a soiled bed for days. The relative reinforced his concerns in an email at 14:41 hours. A social worker marked the referral as requiring an urgent visit. However, no contact was made with Mrs Winterbottom. The following day, a social worker suggested an ambulance be called. When paramedics attended, Mrs Winterbottom was found in a semi-conscious state, lying in her own faeces and vomit. She was covered in pressure sores. She was taken to hospital at 10:11 hours and treated for urosepsis, but died at 19:05 hours the same day.
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) The system for handling urgent referrals within Adult Social Care in Wakefield on 02/06/20 was ineffective. Despite being graded as 'urgent', no contact was made with an elderly, isolated, vulnerable lady, who was evidently in dire need

	of assistance (2) In consequence, Mrs Winterbottom was left alone without the medical assistance which would probably have been called in, had she been seen. It is, however, not possible to say whether her life would have been saved, had she been admitted to hospital on 02/06/20. (3) Even the following day, 03/06/20, no visit took place, despite the urgency of the situation. The urgent referral system was exposed as deficient. (4) Evidence taken at the Inquest indicated that the team in Adult Social Care were now aware of the need to watch out for such cases which had drifted outside of normal hours. Such a generalised instruction serves to diffuse responsibility, rather than establish accountability on the part of an identified manager. (5) There was no safety net in place, whereby an ambulance would have been called in the event the Adult Social Care team were unable to respond in a timely manner for any reason.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe you your organisation 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 20 November 2020. 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: Mr [redacted] (grandson of the deceased). I have also sent it to Dr [redacted], New Southgate Surgery (GP) and Ms [redacted], Community Support Worker, Hatfeild Court, Wakefield (deceased's sheltered accommodation), 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	**24th September 2020**