	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** (1) Director, Suffolk Safeguarding Partnership (2) [redacted], Director, The Limes, Sheltered Housing, London Road, Halesworth
1	**CORONER** I am Jacqueline Devonish, Area Coroner, for the coroner area of Suffolk.
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 26 June 2020 I commenced an investigation into the death of 95 year old May Adalaid Miller. The investigation concluded at the end of the inquest on 7 October 2020. The conclusion of the inquest was that; May Miller died from natural causes precipitated by a violent assault on 9 February 2020, as she slept at her residential care home.
4	**CIRCUMSTANCES OF THE DEATH** This was a very sad death indeed. May Miller, although frail by virtue of her age, was well and happy when she became a resident of Beech House Residential Care Home on 4 February 2020. Whilst in her room asleep on 9 February, 5 days after she arrived at the home, she was attacked by another resident, [redacted], aged 89, with his walking stick. He beat around her head and face. There were defensive injuries to her arms and legs. The Beech House staff heard her screams and attended immediately. Another resident also raised the alarm by pressing the alarm in her own room opposite. On arrival of the carers, Mr [redacted] was standing in the corridor, unable to recall what had happened. It was thought that he was suffering from dementia with periods of lucidity and other periods of hallucination. There had been no assessment. A Warden from the Limes gave evidence that Mr [redacted] had resided at their independent living facility (in a property he purchased) between 16 June 2019 and 4 February 2020 before moving to Beech House. Upon initial assessment the Warden found him belligerent and aggressive and felt there was something not quite right. There was no formal procedure for vetting or assessment except the request for a GP report. Nonetheless, the Limes accepted his application for residency when it went to a committee for consideration. His behaviour deteriorated and appeared to be aggressive and sexually motivated, causing the Warden to feel unsafe. She subsequently stopped visiting him alone, and later, not at all. Mr [redacted]'s daughter gave evidence that her father had had a social worker but had declined a mental health assessment. He had episodes or paranoia but there had been no signs of physical aggression or violence. Prior to approaching Beech House she had applied to Holmwood, Bungay who had refused to accept him due to his declining condition. Beech House's evidence was that they had not been made aware of this information, and could not request information from any professional sources since he was arriving from an unregistered facility.

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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you; The **MATTERS OF CONCERN** as follows:- In light of the data sharing and confidentiality requirements under GDPR, the GP was unable to disclose full information to the Limes or to Beech House about any previous conduct or assessments of [redacted]. At no time was the family of Mr [redacted] asked to sign a letter giving consent to disclosure to other agencies before or after the residency. It was not known whether the GP could have been the central point of contact for all investigative agencies and the Care Homes. It was established during the evidence that multiple investigative agencies may have been aware of Mr [redacted]s risk factors but that due to his not having been admitted to Beech House from a registered facility, that information sharing was not possible. Had there been in place a system for sharing safeguarding information with the Limes and Beech House, there may have been an opportunity to safeguard May Miller.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 3 December 2020. I, the Area Coroner, may extend the period if I consider it reasonable to do so. 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) [redacted], family 2) [redacted], Warden at the Limes 3) [redacted], Director, The Partnership in Care Limited (Beech House) 4) CQC I am 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 Area Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Signed** Jacqueline Devonish **Dated 8 October 2020**