# Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

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| | **REGULATION 28 REPORT TO PREVENT DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1 Derby City Council**<br><br>**2 Derbyshire County Council** |
| **1** | **CORONER**<br><br>I am Sabyta KAUSHAL, Assistant Coroner for the coroner area of Derby and Derbyshire |
| **2** | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 07 February 2023 I commenced an investigation into the death of Emma Irene TURNER aged 30. The investigation concluded at the end of the inquest on 06 January 2026. The conclusion of the inquest was that:<br><br>Emma Irene Turner died on 29th January 2023 at her home address of 2 Betjeman Square Derby. She was profoundly disabled with quadriplegic athetoid cerebral palsy since birth. She lacked capacity. Single and multi-agency processes for discussing Emma's clinical and social care needs were not utilised regularly and in a timely way for her benefit nor were safeguarding adult referrals fully addressed. Speech and language therapists did not see Emma in person for the 11 years between her transition from child to adult services. When she had been assessed by the speech and language therapists, they advised she should only eat pureed food. There was no face to face assessment regarding her clinical needs, her social needs nor adequate welfare checks from 2019 until her death.<br>On 29th January 2023, having eaten some cake, her airway became obstructed as a result of vomit and that sadly resulted in her death. |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br><br>Emma Irene Turner died on 29th January 2023 at her home address of 2 Betjeman Square Derby. She was profoundly disabled with quadriplegic athetoid cerebral palsy since birth. She lacked capacity. Single and multi-agency processes for discussing Emma's clinical and social care needs were not utilised regularly and in a timely way for her benefit nor were safeguarding adult referrals fully addressed. Speech and language therapists did not see Emma in person for the 11 years between her transition from child to adult services. When she had been assessed by the speech and language therapists, they advised she should only eat pureed food. There was no face to face assessment regarding her clinical needs, her social needs nor adequate welfare checks from 2019 until her death.<br>On 29th January 2023, having eaten some cake, her airway became obstructed as a result of vomit and that sadly resulted in her death. |
| **5** | **CORONER'S CONCERNS**<br><br>During the course of the investigation my inquiries 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. |

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| | The **MATTERS OF CONCERN** are as follows:<br>(brief summary of matters of concern)<br><br>It is clear that her family cared and supported her but at the inquest the evidence exposed important issues with information sharing between services. Her mother, her carer should have been given more support and assisted in understanding what was in Emma's best interests.<br>The evidence at the inquest revealed a lack of connectivity between information systems used by different agencies; that impacted on their ability to review how other professionals would intervene in Emma's care. There had been a history of non-attendance and reluctance on the part of family members to engage with services. As a result, safeguarding referrals were made in 2018 by the Day Centre she had attended and in 2019 by a social worker after her discussions with the advanced nurse practitioner at the GP surgery.<br>Although the evidence from the GP surgery, Derby City Council and their safeguarding team confirm that since Emma's death a number of relevant changes were being made to look after patients with learning difficulties particularly where they have not been brought to multiple appointments, in so far as the contents of the present safeguarding referral form which needs to be completed by a GP for vulnerable and learning difficulties adults, that present form is not tailored to the type of concerns that a GP would raise. The safeguarding template questions ask a variety of questions that are not relevant to a GP but to other agencies e.g. care homes, the police and community mental health teams. As a result there is a risk of there being a lack of key information provided to the safeguarding teams. Thus the safeguarding team may be delayed in responding in a timely way. |
| **6** | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by April 23, 2026. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons<br><br>Derby City Council<br>The Council House<br>Corporation Street<br>Derby<br>DE1 2FS<br><br>Derbyshire County Council<br>County Hall<br>Matlock<br>Derbyshire<br>DE4 3AG<br><br>I have also sent it to<br><br>[redacted], **Derby city council Adult social care legal rep**<br><br>who may find it useful or of interest. |

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| | I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.<br><br>I may also send a copy of your response to any person who I believe may find it useful or of interest.<br><br>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.<br><br>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** | **Dated: 25/02/2026**<br><br>[redacted]<br>**Sabyta KAUSHAL**<br>**Assistant Coroner for**<br>**Derby and Derbyshire** |