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.** Sean Harriss, Chief Executive, Bolton Council, Town Hall, Victoria Square, Bolton.
1	**CORONER** I am Jennifer Leeming, Senior Coroner for the Coroner Area of Manchester West
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 18th of September 2013 I commenced an investigation into the death of Keith Samuel Peters aged 57 years. The investigation concluded at the end of the inquest on the 3rd of December2013. The conclusion of the inquest was that Keith Samuel Peters had died as a consequence of misuse of alcohol. The medical cause of his death was 1a Haemorrhagic pancreatitis 1b Alcohol abuse II Alcoholic liver disease.
4	**CIRCUMSTANCES OF THE DEATH** 1. Keith Samuel Peters lived alone at 4, Royston Avenue, Bolton. He suffered from Type II diabetes, chronic pancreatitis and alcohol dependence. His only carer was his sister, [redacted] who lived some distance away, but visited her brother each week. 2. On the 1st of August 2013 Mr Peters was visited by his General Practitioner, (GP) who was concerned about his condition. The Doctor was particularly concerned that Mr Peters was not eating properly. He therefore referred Mr Peters to Bolton Council Social Care Services on the basis that Mr Peters was having problems with self care and meal preparation. The referral was made with normal priority. 3. The referral was received by Bolton Council North STARS team on the 2nd of August 2013. The policy of that team is that there should be meaningful contact with the subject of such a referral, in this case Mr Peters, within two weeks of the receipt of the referral and that the needs of the subject should be assessed within twenty eight days of such receipt. 4. A member of the North STARS Team did contact Mr Peters promptly and arrangements were made for him to have a key safe installed and for him to receive hot meals from the Meals on Wheels Service. However these arrangements were made without there having been any assessment of Mr

	Peters' needs and the North STARS Team were therefore unaware that Mr Peters was unable to eat solid food. Accordingly Mr Peters could not eat the meals that were delivered and he telephoned the Community Meals Office on the 3rd of September 2013 and cancelled the meals, explaining that he was not eating them. 5. Meanwhile on the 15th of August 2013 Mr Peters' case was allocated to a Community Assessment Officer within the North STARS team with a view to Mr Peters' needs being assessed on or before the 29th of August 2013 as the Team's Policy required. However the Officer to whom the case was allocated was on annual leave at that time. The Officer was due to return to work on the 19th of August, but had arranged further leave from the 22nd to the 28th of August. This meant that there were only four days within the twenty eight days allowed by the Policy during which the Officer could contact Mr Peters, arrange to interview him and complete the assessment process. 6. The Officer telephoned Mr Peters on the 21st of August 2013, the day before she was due to go on leave again, in order to arrange an appointment to see him. There was no answer to her call and she left a message asking Mr Peters to contact her. Mr Peters responded to the message on the 23rd of August by telephoning the North STARS Office. It was recorded that he was told that the relevant Officer was on leave and that she would telephone him upon her return. 7. The Officer telephoned Mr Peters on the 3rd of September, which was the fifth working day after her return from leave, and five days outside the twenty eight day period allowed for his assessment to be completed. She reported that the telephone number was unobtainable and she arranged for a letter to be sent to Mr Peters asking him to make contact with her. 8. On the 5th of September Mr Peters responded to the letter by telephoning the Office of the North STARS team, and the Officer was advised of his call. 9. On the 8th of September Mr Peters was visited by his sister, who was so concerned about his condition that an ambulance was called and Mr Peters was taken to the Royal Bolton Hospital where he was found to be extremely cachectic and was admitted to the High Dependency Unit where he died on the 12th of September 2013. 10. On the same date, the 12th of September, Mr Peters' Community Assessment Officer returned the call that Mr Peters had made to her Office on the 5th of September. She received no reply.
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: Brief circumstances of matters of concern (1) Mr Peters' case was allocated to a Community Assessment Officer who was on leave at the time, and whose future leave commitments resulted in her having limited time to complete Mr Peters' assessment within the required period. (2) During the periods when the Community Assessment Officer was

	available there is no evidence of Mr Peters' case being prioritised, neither when the twenty eight day period allowed for the assessment to be completed was approaching expiry, nor when that period had expired. (3) The manager of the North STARS team gave evidence at the Inquest that there was no system in place for Officers to refer a case back to the Manager for re allocation to another Officer when it became clear that an assessment was not going to be completed within the twenty eight days required.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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** You are under a duty to respond to this report within 56 days of the date of this report, namely by the 6th of February 2014. 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: [redacted], Mr Peters' sister. I have also sent it to [redacted] Mr Peters' GP. 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	**Dated** 12th December 2013 **Date**
	Signed M Tennyson. **Coroner's Name**