**ANNEX A**

**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

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

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. London Borough of Tower Hamlets – Social Services**<br>**2. [redacted] (Family – Interested person)** |
| 1 | **CORONER**<br><br>I am Gail Elliman, Assistant coroner, for the coroner area of Inner North London |
| 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 16 April 2014 I commenced an investigation into the death of Harold George de Mello, born on 13 April 1926. The investigation concluded at the end of the inquest on 7 July 2014 The conclusion of the inquest was that Harold de Mello died of bronchopneumonia and that this was a natural cause but was contributed to by neglect. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>The circumstances of the death were that Harold de Mello suffered from a number of co-morbidities – diabetes, hypertension, osteoarthritis and spinal stenosis, he was not mobile (using a wheelchair or mobility scooter outdoors and a wheeled zimmer frame in the home). He suffered from incontinence and there were related problems of personal hygiene and lack of care noted by his doctor. His incontinence was assessed in November 2013 and he was referred to a District Nurse for an incontinence assessment and given the details of Age UK and his case closed. A call from a concerned neighbour (on behalf of a voluntary organisation in the community called 'Friends and Neighbours') was made in February 2014 and this prompted a further visit and a further assessment on 27 February 2014. This assessment concluded that Mr de Mello did not require care in his home and his case was again closed. The next day he presented to his GP and was noted to be unkempt with urine and faeces on his clothes (his underwear). He appeared to believe that he was still under assessment by Social Services and possibly still under investigation for the incontinence. On 1 April 2014 he collapsed in his home and an ambulance was called when neighbours heard him calling for help about four hours after his reported collapse. The ambulance service noted that he was covered in urine and faeces and had rotting food in his home. A safeguarding alert was made and he was taken to the Royal London Hospital where he was treated for the bronchopneumonia but died at the hospital on 13 April 2014 which was considered to have been caused by the lack of hygiene and, therefore, the neglect and conditions in which he had been living. |
| 5 | **CORONER'S CONCERNS** |

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| | 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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) that there are no good practice guidelines for assessments that are being carried out leading to the fact that:<br>(2) a First Response Officer could go to a person's home, could be told that it was OK to look in the occupant's bedroom but feels it is 'inappropriate' to do so despite the fact that there have been concerns about the service user's incontinence and personal hygiene from the referrer including a report as to the bedding being soiled with urine and faeces. Assessments should be made bearing in mind the referral and the actual concerns made and should be comprehensive, particularly when a service user has agreed to the assessment and examination proposed<br>(3) that, given that a conclusion was made that there would be no social care provided, the assessment was made (and signed off by a senior colleague) without any reference to the rather different reports from the referrer and in the deceased's historical record. There is an incongruence between the claimed observations of the First Response Officer and the information that led to the assessment that was not explored<br>(4) that no reference was made to any of the people to whom the service user referred as being carers, that information was wrongly recorded (a person wrongly described as a niece who was not a relative) and that there is a significant difference in the fact that the visit assessment suggests that the deceased had adequate social care whilst also noting that a 'carer' was not fit and able to undertake domestic tasks. That no investigation was properly made into the actual care available to Mr de Mello and no contact made with either the claimed carer or the relative with power of attorney to confirm the reality of his situation and the extent of his dependence or needs<br>(5) that there was a difference in the actions recorded in the assessment (apparently the ordering of urine bottles) and the letter written to Mr de Mello stating that a commode had been ordered and no consideration of whether he could use a commode<br>(6) guidelines should, therefore, refer to both the manner and the recording of the assessments and senior colleagues should thoroughly check assessments against the referrals or reports made |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe London Borough of Tower Hamlets Social Services 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 . 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 – [redacted]<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<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. 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 | **[DATE]** **[SIGNED BY CORONER]** |

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