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:** [redacted] **Business Manager - Eastern Region** **Centra Support** **Central House** **1-3 Highbury Station Road** **London N1 1SE** [redacted] **Managing Director** **Centra Support** **Central House** **1-3 Highbury Station Road** **London N1 1SE**
1	**CORONER** I am JACQUELINE LAKE, senior coroner, for the coroner area of NORFOLK
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 7 August 2014 I commenced an investigation into the death of MICHAEL TERENCE HARMAN, AGED 73 years. The investigation concluded at the end of the inquest on 20 November 2014. The conclusion of the inquest was medical cause of death: 1a) Pneumonia; 1b) Hypernatraemia and Dehydration; 1c) Neglect; 2 Ischaemic Stroke (Old) Acute Kidney Injury and a narrative conclusion: "Mr Harman was seen on 18 July 2014. He was then spoken to daily but not seen. On 28 July 2014 he was seen and due to concerns regarding his welfare he was taken to Hospital. His condition deteriorated and he died on 3 August 2014."
4	**CIRCUMSTANCES OF THE DEATH** Mr Harman lived in a sheltered housing scheme, offering independent living with support offered as and when required and signposting to other services as requested by the tenant. An emergency pull cord is in place and no face to face contact unless requested. He was seen by a support Co-Ordinator on 18 July 2014 when his flat was messy (unusual for him), he had soiled himself, he had "clearly been drinking [alcohol] but was not drunk". He was partially dressed with soiled pyjama bottoms by the side of his chair. He refused assistance to clean himself saying he would do this himself. A warden gave evidence that he later saw Mr Harman through a glazed door near to his bathroom. Attempts were made to contact Mr Harman's family: a nephew agreed to try and call on him. Mr Harman was at this time receiving the maximum amount of support offered by this form of independent living. He was felt by the Co-Ordinator to have mental capacity.

	A cover support Co-Ordinator contacted Mr Harman by intercom each day from 21 to 25 July 2014 when he did stated he did not require any extra support. On 28 July 2014 the original support Co-Ordinator returned from holiday and there was limited response from him via the intercom – he made a "noise". The Support Co-Ordinator entered the property and found Mr Harman unresponsive, naked, collapsed in his chair and having soiled himself with soiled clothes on the floor. He was taken to Hospital and diagnosed with acute kidney injury secondary to severe dehydration. He had a grade 2 large pressure sore covering his buttocks and the backs of his thighs. The evidence of the Doctor was that this was most likely caused by a lengthy period of immobility and sitting in excrement. Despite treatment, Mr Harman died.
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) After being found in a soiled condition, no check was made on Mr Harman to ensure he had cleaned himself as he said he would do. (2) There were several indicators that Mr Harman's condition had possibly deteriorated to a point where he was no longer suitable for independent living, such as his flat being unusually untidy, his relapse in respect of drinking alcohol, his having soiled himself, his physical problems (he had recently been diagnosed with cellulitis). He was also receiving the maximum amount of support which could be offered. (3) Reviews of a tenant such as Mr Harman are annual, unless the tenant requests a review. No thought had been given to anyone else carrying out a review of Mr Harman's condition particularly in the light of the above factors (4) Handover notes between Co-Ordinator and Cover Co-Ordinator deal with whether a tenant is likely to be at home when the intercom call is made. No note was made requesting a check to be made to ensure Mr Harman had cleaned himself up.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 23 January 2015. 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] and [redacted] Legal Services & Complaints Manager at Norfolk & Norwich University Hospital I have also sent it to:

	[redacted] Director of Community Services at Norfolk County Council 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	**25 November 2014** **……** **[SIGNED BY CORONER]**