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] **Director of Community Services – Adult Social Care** **Norfolk County Council** **County Hall** **Martineau Lane** **Norwich NR1 2DH**
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 12 March 2014 I commenced an investigation into the death of DARREN HAYES, Age 48 years. The investigation concluded at the end of the inquest on 11 December 2014. The conclusion of the inquest was medical cause of death: 1a) Poisoning by morphine and benzodiazepines 2 Empyema of the gallbladder and short-form conclusion: Drug Related Death.
4	**CIRCUMSTANCES OF THE DEATH** Mr Hayes had a number of physical health problems for which he was prescribed a large number of medications. He had a long history of opiate dependence and alcohol abuse. From January 2014 he was noted to be not eating and losing weight. He was not supposed to be drinking alcohol due to chronic pancreatitis but continued to do so. He was referred to Adult Social Care, Norfolk County Council (NCC) on 10.01.14 on discharge from James Paget University Hospital (JPUH) by Norfolk Recovery Partnership, and by Support Worker, Stonham Housing, as he had could not eat or prepare meals properly, struggled with personal care, his weight was under 7 stone, lived alone and had no cooker. It was arranged he would receive care in his home 3 times per day from Norfolk First Response Service. He also received assistance from the Red Cross. On 16.01.2014 he was readmitted to JPUH following a fall and discharged 17.1.2014. He again went to JPUH on 18.1.2014.

	He was readmitted to JPUH on 10.2.2014 with severe dehydration, lack of nutrition and confusion. Norfolk First Response Service (NFRS) discharged him as he was staying in JPUH. He was discharged home on 18.2.2014. A full Community Care Assessment was not completed by a Social Worker as Mr Hayes said he could manage. He said he was considering referral for rehousing to include more support. He agreed to a possible referral to a Day Centre. The Social Worker had no concerns as to his mental capacity. The Social Worker believed he had a District Nurse visiting regularly (daily?) and he was receiving assistance from the Red Cross. On 26.2.2014 The Red Cross discharged him from their service as he wanted them to buy him alcohol. On 27.2.2014 The Social Worker arranged for Mr Hayes to be assessed for a possible Day Centre. He was telephoned on 27.2.14, 28.2.14, 3.3.14, 4.3.14 and 5.3.14 with no response. On 6.3.14 he was spoken to and agreed to a face to face assessment and was referred to the Eastern Community Care Team (ECCT) on 10.3.14 with the same information as provided on his discharge from JPUH on 10.1.14. He was allocated for assessment on Friday 28.3.2014, which was due to take place on Monday 31.3.2014. Sadly, Mr Hayes died in the meantime on 11.3.2014, before the assessment could take place. ECCT continued to try to contact Mr Hayes by telephone .On 1.4.2014, a letter was sent out and then further attempts to contact Mr Hayes by telephone on 16.4.2014, when the Team was advised Mr Hayes had 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) Attempts to contact Mr Hayes by telephone were not documented nor escalated to a senior worker – it is understood NCC have taken steps to ensure that staff are aware that all calls (even those where there is no response are documented) and a senior member of staff is made aware; (2) The time taken to contact Mr Hayes in the light of the information provided and the risks with which Mr Hayes was presenting. The initial referral to the ECCT was on 10.3.2014, he was allocated for initial assessment which was due to take place on 28.3.14; 3 weeks later. The first attempt to telephone Mr Hayes was on 1.4.2014. A letter was sent to Mr Hayes and on receiving no response, there was no further attempt to contact Mr Hayes until 16.4.2014, almost 5 weeks after both the initial referral and his death. (3) The risks with which Mr Hayes were not fully considered ie his diabetes being "out of control", weighing less than 7 stone, lacking motivation, struggling to manage at home, living alone and having no cooker . He was no longer receiving 3 daily visits from NFRS. The evidence was that Mr Hayes had a microwave and could make himself "a hot drink". (3) Despite getting no response to telephone calls or letter, SW did not contact GP, District Nurse or Red Cross (who had discharged him)
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 12 February 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. 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	**17 December 2014** ..... **Jacqueline Lake, Senior Coroner**