REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

This report is made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013

Recipients

This report is being sent to:

Chief Executive, Northern Eastern and Western Devon Clinical Commissioning Group

Chief Executive, Torbay & South Devon Clinical Commissioning Group

Chief Executive, Plymouth City Council

Chief Executive, Devon County Council

Chief Executive, Torbay Council

Coroner

I am IAN MICHAEL ARROW, Senior Coroner for the area of Plymouth, Torbay & South Devon

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

Investigation and Inquest

On the 15th October 2013 I commenced an Inquest into the death of Andrew John Nickolls. The Inquest concluded on the 10th June 2015.

The medical cause of death was found to be:

1a Unascertained

The conclusion of the Inquest was "Open".

The deceased was found dead and decomposing at Flat 11 Newcomen Court, Dartmouth. On the balance of probability. The Coroner heard evidence he had been consuming a significant amounts of alcohol. He had previously had numerous hospital admissions.

Circumstances of death

The deceased was discharged from Torbay Hospital on the 12th September 2013. When a cause for concern was raised he was found by Police Officers in his flat.

Coroner's concerns

During the course of the Inquest I received evidence by way of a detailed report from [redacted] giving rise to concerns. 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:

The pertinent circumstances of Andrew's death were that he was living in Dartmouth. He was registered with a GP in Plymouth. He attended Torbay Hospital on numerous occasions.

Following his death the Torbay & South Devon Clinical Commissioning Group conducted an investigation into the circumstances of his death. This investigation was carried out by [redacted] A copy of her report with substantial recommendations has been shared with the NEW Clinical Commissioning Group and the Torbay & South Devon Clinical Commissioning Group. I also understand copies are to be shared with The Chief Executive of: Plymouth City Council, Devon County Council and Torbay Council.

The principal learning point is to be that there is an advantage in a patient being looked after by a primary carer (i.e. a GP) **within** the Clinical Commissioning Group. If this is not the case, **then it is imperative** that there is clear information sharing, particularly where there is a vulnerable adult and there is a possibility they are neglecting themselves.

May I observe there may be an advantage in sharing information with Devon & Cornwall Police who clearly keep an index of vulnerable individuals as these individuals may come to the Forces notice through other routes.

Action should be taken

I would ask you please to consider what steps could be taken to ensure there is prompt exchange of information about an individual's personal circumstances and where appropriate, should they be a vulnerable individual, for them to be provided support from a Safeguarding Adult team.

Your response

You are under a duty to respond to this report within 56 days of the date of this report namely, 12th August 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.

Copies and publication

I have sent a copy of my report to The Chief Coroner and to the following interested persons

The Chief Constable of Devon & Cornwall Constabulary

[redacted] MP for Totnes and Chair of the Health Select Committee

Secretary of State for Health

Family members

I am 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 to the Chief Coroner

I.M. ARROW **Dated 17th June 2015**
Senior Coroner – Plymouth, Torbay & South Devon