REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive of Cornwall Council** **(Director of Adult Care, Health and Wellbeing)** **Local Adult Safeguarding Board**
1	**CORONER** I am the Senior Coroner for the coroner area of Cornwall
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** **Colin Keith Williams**
4	**CIRCUMSTANCES OF THE DEATH** Colin Williams was found dead at his home address, 18 Tregonissey Close, St Austell on 9th April 2013. He was found lying on the kitchen floor with three jackets on, over his top and trousers in a state of decomposition. The house was well heated but in a neglected state (plates with mouldy food around house, all surfaces covered with hoarded items/medication) with evidence of Mr Williams excessively abusing alcohol. He was last known to be alive on 17th March 2013. It was not possible to establish the cause of death or whether neglect played a part in the death on the evidence at inquest. Mr Williams was well known to numerous agencies e.g. Social Service, GP, police, RCHT, social houses and was known to be a vulnerable adult and to self-neglect [redacted]
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. – Mr Colin Williams was known to numerous agencies and personnel. At inquest evidence was given from Ocean Housing, Adult care, Health and Wellbeing, Taylors of Grampound, the Police, Royal Cornwall Hospital (together with minutes of Complex planning meetings arranged by Cornwall Council on 11.11.12, 13.03.12) the extent of his complex needs and tendency to self-neglect, particularly when under the influence of alcohol. Despite being known to have complex needs his body was not found for some weeks. Those at inquest gave evidence that due to the large number of potential agencies involved in his care, his age (below 65), and the fact he had variable mental capacity due his chronic alcoholism (no mental health diagnosis) it made it difficult for Mr Williams to know which agency provided what service and whether they were free or

	not. This led to agency "blindness" preventing him from accessing help/funding particularly at a time of crisis (especially when he lacked capacity due to alcoholism). An example was given by Ocean Housing who had been involved with Mr Williams since 2011. Initially he was provided support through this tenancy which was funded by Cornwall Council supporting people budget. In 2011 the way funding was provided was changed and Mr Williams no longer qualified. An independent living service was set up in lieu which clients had to contribute towards. From this time forward Mr Williams did not engage as he had difficulty in understanding the structure. His funding was made more complicated by hospital admissions/care home placements which meant on occasions he was left without funds due to the necessary paperwork being completed – which he was unable to complete or understand on his own. Those at inquest considered that this was not an uncommon scenario; particular when a client had both health and social issues and this was made even more difficult if they were drug and/or alcohol dependant.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations have the power to take such action. To review the structure and interagency approach in supporting clients with multiple social and health needs (in particular to those with drug and/or alcohol dependency) to provide a more "joined up" approach to the client with consideration of key workers.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Friday 11 March 2016. 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] and to the LOCAL SAFEGUARDING BOARD. I have also sent it to Public Health Commissioning Group 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	**11 January 2016** **SIGNED BY CORONER – DR E E CARLYON** Elizabetti Emma Carlyon