	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **WILLIAM LUGG (died 6 March 2018)** **THIS REPORT IS BEING SENT TO:** **1.** [redacted]**,** **Director,** **Careworld London Ltd,** **The Whitechapel Centre,** **85 Myrdle Street,** **London E1 1HL** **2.** [redacted] **Head of Service,** **Careworld London Ltd,** **The Whitechapel Centre,** **85 Myrdle Street,** **London E1 1HL** **3.** [redacted]**,** **Senior Solicitor,** **London Borough of Tower Hamlets,** **Mulberry Place,** **5 Clove Crescent,** **London E14 2BG**
1	**CORONER** I am Heather Williams QC, Assistant Coroner Inner North London Poplar Coroner's Court, 127 Poplar High Street, Tower Hamlets, London E14 0AE
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 2018 an investigation was commenced into the death of William Lugg, aged 68 years old. The investigation concluded at the end of the inquest on 20 June 2018. The inquest found that Mr Lugg died on 6 March 2018 at his residence at Flat 29 Maude House, Ropley Street, London E2 following an unwitnessed fall when he was ascending the stairs at that address, which occurred on / by the morning of 3 March 2018. The conclusion of the inquest was a narrative one (see 4. below). The medical cause of death was found to be: 1a head injury.
4	**CIRCUMSTANCES OF THE DEATH** Mr Lugg lived alone and had not left his residence for several years. He suffered from severe depression. He was under the care of the Tower Hamlets Adult Social Care

	Team and received daily care visits from staff employed by the Careworld London care agency and also Meals on Wheels. From the morning of 3 March 2018 onwards, the Careworld carer and the Meals on Wheels personnel received no answer upon their daily attendances at the premises. This was unusual. Careworld did not contact the Tower Hamlets Out of hours service or the police over the weekend of 3 – 4 March 2018. They conveyed inaccurate information to Tower Hamlets on 4 and 5 March 2018. The premises were not attended until 6 March 2018 by Tower Hamlets Adult Social Care Staff, when police were contacted for the first time. Once entry was gained, Mr Lugg was discovered, deceased, having fallen down the stairs. It is not clear whether or not earlier intervention, following the fall, would have saved him.
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 could 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) Tower Hamlet's Failed Visits Procedure was poorly understood and not followed by Careworld staff, in particular (though not limited to): (a) the appropriate means of alerting Tower Hamlets to failed care visits that occurred during a weekend; and (b) use of the Tower Hamlets' pro forma Failed Visit Record; (2) Careworld's own Failed Visits Procedure does not mirror or reflect aspects of Tower Hamlet's prescribed procedure; (3) Vital information regarding the identity of and contact details for the only other keyholder to the premises in this instance was not clearly recorded by either Tower Hamlets or Careworld; (4) No adequate record of calls from a carer to the Careworld Care Co-ordinator regarding failed visits was made, leading, in turn, to inaccurate information regarding the client's welfare being disseminated to Tower Hamlets by another member of Careworld staff; (5) Neither Tower Hamlets or Careworld's Failed Visits policy gives any / any sufficient prominence to the possibility of involving the police if other attempts to confirm the individual's welfare following a failed visit have proved unsuccessful; (6) The absence of a clear / clearly understood system for the Adult Social Care Team to use on a Monday morning for assessing and deciding the priority of referrals from the Out of hours service made over the weekend (and for recording this decision-making).
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or your organisations 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 20 August 2018. 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. (Mr Lugg has no living family members.) 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 June 2018**