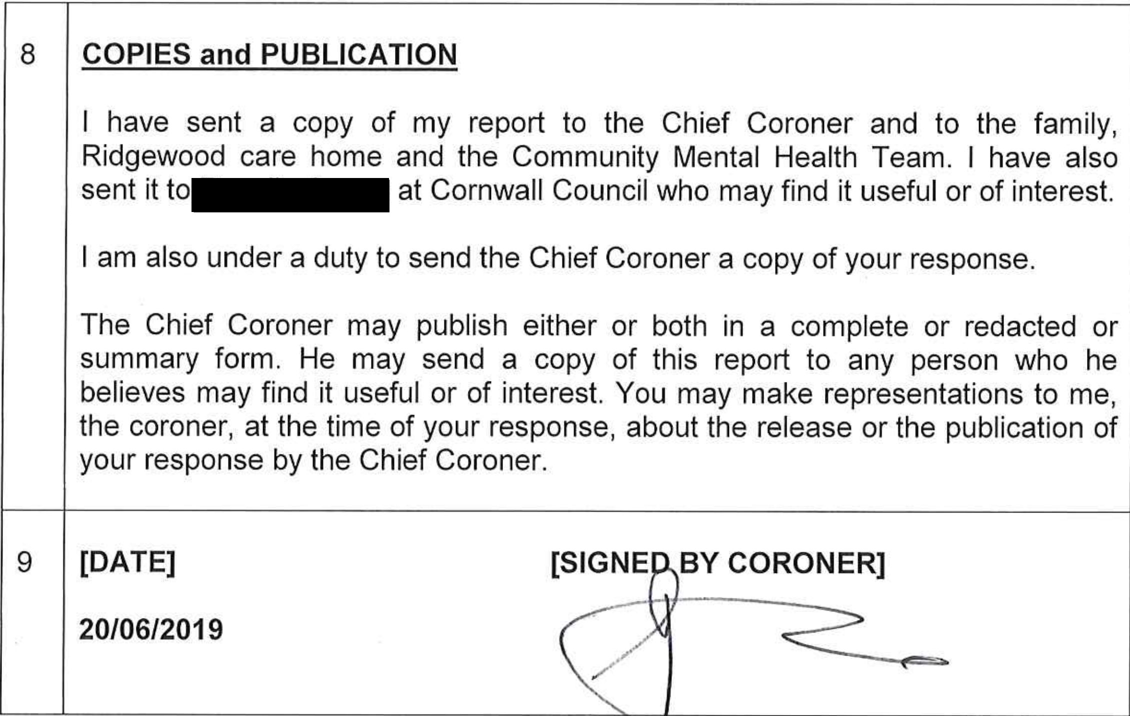
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

Michael John Owen COX, deceased

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Strategic Commissioner (Children's, Families and Adults) Cornwall Council
1	**<u>CORONER</u>** I am Andrew Cox, Acting Senior Coroner for the coroner area of Cornwall and the Isles of Scilly.
2	**<u>CORONER'S LEGAL POWERS</u>** 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	**<u>INVESTIGATION and INQUEST</u>** On 08/09/2017, an inquest was opened into the death of Michael John Owen Cox who died at Ridgewood Care Home, [redacted] in Cornwall on 01/04/2017. The inquest concluded, after a four-day hearing before a jury, on 13/06/2019. The jury recorded a conclusion of misadventure due to drug/alcohol use.
4	**<u>CIRCUMSTANCES OF THE DEATH</u>** Michael had a long history of mental illness. He had previously been diagnosed with paranoid schizophrenia and had been detained under section 3 of the Mental Health Act. This had been suspended and a Community Treatment Order was in place. For a number of years, Michael had lived at a specialist facility in Wales. In 2016, the therapeutic relationship broke down and Michael was recalled to Fletcher Ward at Bodmin hospital. There were concerns about his drinking and he agreed to enter a detoxification programme. His consumption of alcohol, however, did not appear to affect his mental health and at the time of his recall he was not acutely unwell. As he was not acutely unwell, it was recognised that the hospital ward was not an appropriate venue for him to live. Attempts were made to find a placement for him in the east of the county but these were unsuccessful. Michael's history of

	threatening violence to others and being involved in assaults together with previous episodes where he set fire to property and himself is likely to have been a factor in the number of placements that were potentially available. A placement was found for Michael at Ridgewood care home in Camborne. He moved there in July 2016. The home had a zero tolerance policy to alcohol. In March 2017, it became apparent that Michael had been drinking secretly and it seems likely (although there is no evidence of this) that this had been on-going for some time. There had been no witnessed deterioration in his mental health or mood. The situation was discussed with the Responsible Clinician and others. As there had been no deterioration in his mental health, there was no basis in law for recalling Michael to the acute ward. The care home, however, did not have staff with qualifications or experience in dealing with clients who had addiction or substance misuse issues. Michael was found deceased in his room on the morning of 01/04/2017.
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. – The potential shortage of suitable placements for individuals with a mental health history similar to Michael. Evidence was heard at the inquest that when such individuals are placed at a suitable facility, it can become their home and they may live there for years and even decades. Accordingly, spare places can be at a premium. Evidence was also heard that social workers (and in this case an occupational therapist) have persistent difficulties in finding suitable placements suggesting that resources are limited.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. I would be grateful if you would consider, in light of this death, whether there is an adequate stock of available accommodation for individuals who present with the challenges apparent in someone like Michael.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 16th August 2019. 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 family, Ridgewood care home and the Community Mental Health Team. I have also sent it to at Cornwall 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	**[DATE]** **[SIGNED BY CORONER]** **20/06/2019**