REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Adullam Homes Housing Association
1	**CORONER** I am Joanne Kearsley, Senior Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 3rd December 2020 I commenced an investigation into the death of **Liam Kenyon** the Inquest concluded on the 18th May 2021.
4	**CIRCUMSTANCES OF DEATH** At the time of his death Mr Kenyon was residing in the supported housing accommodation Bury Bridges, part of the Adullam Homes Housing Association estate. The Court heard the local authority contract with the housing association to provide supported accommodation for vulnerable persons who may have issues such as substance abuse. Mr Kenyon had been homeless and had a longstanding addiction to prescribed diazepam in addition to illicit drug use. However from the evidence before the Court at no stage had his illicit drug use involved opioids, either heroin or methadone. On the 17th July 2020 Mr Kenyon was found unconscious in his room. Paramedics from North West Ambulance Service attended and suspected Mr Kenyon had taken an overdose of opioids. He was treated with naloxone to which he responded. Mr Kenyon refused hospital admission. He was deemed to have capacity to make this decision. Evidence from the paramedics indicated they remained concerned that Mr Kenyon may relapse once the effects of naloxone wore off. As such a plan was agreed with the support staff from the housing association that they would monitor Mr Kenyon. The paramedics advised the Court that as Mr Kenyon was going to be monitored by the support workers they did not consider asking Mr Kenyon if he wanted them to contact family to assist him. Shortly after the paramedics left an email was sent by a Senior Project Manager at the housing association to conduct hourly checks at 232 (the premises) to ensure the safety of Liam. The Court heard Liam was last seen by a member of staff at 22.45pm on the 17th July. When staff entered his room on the 18th July 2020 at 15.00 hours he was found deceased.
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. The evidence highlighted a lack of clarity as to the extent of the care provided by the supported housing association and how staff interpret this. The Court was informed that the housing association have a "*duty of care to its residents*" and that this included "*safeguarding residents*" and the "*risk management of residents*". However when the situation arose on the 17th July 2020 the Court was advised the housing association are not care providers and should not have become involved in the plan to monitor Liam. 2. Having agreed with the support plan and this being confirmed in an email to staff, hourly checks were not conducted on Liam. 3. The Court heard following the incident on the 17th July the procedure of asking Liam if a drug check of his room could be conducted was not done. 4. In addition following him being found unconscious due to a suspected overdose the Court heard his risk assessment should have been updated and this was not done. 5. The Court heard that on the 18th July a staff member went to Liams room on three occasions (from 10am) and knocked on the door receiving no response. The Court heard that where no response was received a physical welfare check involving 2 members of staff entering the room using the master key should have occurred. 6. The Court heard that at a weekend there are less staff to cover all the sites and on the 18th July the staff were dealing with a number of incidents involving residents, meaning to conduct hourly checks would have been difficult. However no member of staff escalated to the on call manager the fact that there were problems. 7. Finally the Serious Incident Review process which is in place to learn lessons from such incidents was deficient and ineffective.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 **14th July 2021**. 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 namely:- The family of Mr Kenyon Chief Executive of North West Ambulance Service A copy has also been sent to Bury Council who contractually commission this service. 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 from. 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: 19th May 2021	Signed: