




## North East Kent Coroners

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	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <p>1. The Director of Adult Services at Kent County Council</p>
1	<p><b>CORONER</b></p> <p>I am Ian Brownhill, assistant coroner, for the coroner area of North East Kent</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>Hadley John Savory was found dead at his home address in Margate on 13 December 2019. An investigation into his death was commenced. The investigation concluded at the end of the inquest on 11 August 2021. My conclusion was that his death was drug related, in addition, a short narrative conclusion was given as explained further under section 4 below.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>Hadley John Savory was discharged from Queen Elizabeth The Queen Mother Hospital on 25 September 2019. A multi-agency meeting did not take place prior his discharge from hospital. The plan for Mr Savory's care, support and treatment in respect of his substance misuse, physical health, mental health and social care needs is unclear.</p> <p>Mr Savory's presentation declined in the community. Safeguarding referrals were made but no multi agency meetings were convened pursuant to safeguarding duties under the Care Act or as per the Kent and Medway Multi-Agency Policy and Procedures to Support People that Self-Neglect or Demonstrate Hoarding Behaviour.</p> <p>Police made entry into Mr Savory's home address on 13 December 2019, he was found to be deceased. Toxicological evidence indicated that Mr Savory had taken a lethal dose of methadone. There was no evidence that Mr Savory had intended to take an overdose.</p>
5	<p><b><u>CORONER'S CONCERNS</u></b></p>

	<p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <ol style="list-style-type: none"> <li>(1) There was no evidence of a multi agency planning meeting prior to Mr Savory’s discharge from Queen Elizabeth The Queen Mother Hospital on 25 September 2019. Nor was there evidence of what multi-agency procedures are in place relating to the safe discharge of patients with concurrent, mental health, substance misuse, social care and physical health needs;</li> <li>(2) There was no recording (or available evidence of recording) of attempts to escalate internal disagreements as to which team Mr Savory should have been allocated to. Nor did the evidence establish how internal disagreements as to allocation of cases are recorded;</li> <li>(3) The evidence was not clear as to how eligible care needs under the Care Act are met when a service user is transferring between services. In Mr Savory’s case he was assessed as having eligible needs but no care and support plan was developed;</li> <li>(4) The evidence demonstrated that there was a lack of clarity as to the interrelationship between safeguarding duties under the Care Act and the operation of the Kent and Medway Multi-Agency Policy and Procedures to Support People that Self-Neglect or Demonstrate Hoarding Behaviour;</li> <li>(5) It was unclear as to how information sharing operated in respect of service users who are identified as potentially having fluctuating mental capacity in respect of their care and support needs.</li> </ol>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by <b>6 October 2021</b>. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to:</p> <p>The Chief Coroner  The family of Hadley John Savory  The Chief Executive of the East Kent Hospitals University NHS Foundation Trust  The Chief Executive of The Forward Trust  The Chief Executive of Kent and Medway NHS and Social Care Partnership Trust</p> <p>The legal representatives of the above.</p> <p>In addition, I have sent this to:</p> <p>The Independent Chair of the Kent and Medway Safeguarding Adults Board</p> <p>I may also send a copy of your response to any other person who I believe may find it</p>

	<p>useful or of interest.</p> <p>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.</p> <p>You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.</p>
9	<p>Signature: </p> <p>Ian Brownhill Assistant Coroner North East Kent</p> <p>11 August 2021</p>