Regulation 28: Prevention of Future Deaths Report

Mr Robert Hammond (died 30 January 2021)

THIS REPORT IS BEING SENT TO:

1. [redacted] - Chief Executive at Coventry & Warwickshire Partnership Trust, Wayside House, Wilsons Lane, Coventry CV6 6NY

1. CORONER

I am: Sean McGovern, Senior Coroner for Warwickshire, Warwick Justice Centre, Newbold Terrace, Royal Leamington Spa.

2. CORONER'S LEGAL POWERS

I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and

The Coroners (Investigations) Regulations 2013, regulations 28 and 29.

3. INVESTIGATION and INQUEST

On 5th February 2021, I commenced an investigation into the death of Mr Hammond (aged 55 years). The investigation concluded at the end the inquest on 2nd December 2021 at Warwick Coroners Court.

4. CIRCUMSTANCES OF THE DEATH

Mr Hammond [redacted] and was found in his home address on 30th January 2021. He received treatment from the Trust from 20 December 2020 to 30 January 2021. He had a co-dependant relationship with his father who was admitted to hospital on 20 December 2020 and died two days later.

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5. CORONER'S CONCERNS

During the inquest, the evidence and information 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:

i. During the inquest there was evidence that Working with Risk (WWR) documentation was not completed on approximately the first nine contacts with Mr Hammond. The 1st contact was on 23rd December 2020 where 2 hours had been allocated for this task as well as the initial assessment and care plan – none of the written documents were completed. The WWR documents were also not completed (on subsequent contacts) on 31/12/20, 3/01/21, 4/01/21,5/01/21, 6/01/21, 7/01/21, 8/01/21, 10/01/21 and 11/01/21. The Trust was unable to give an explanation for these failures. As a result, the care plan for Mr Hammond was unsatisfactory.

6. ACTION SHOULD BE TAKEN

In my opinion, action should be taken to prevent future deaths and I believe that you 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 31st January 2022. 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 following:

1. HHJ Teague QC the Chief Coroner of England & Wales Chief Coroner's Office, 11th Floor Thomas More, Royal Courts of Justice, Strand, London, WC2A 2LL. chiefcoronersoffice@judiciary.gsi.gov.uk

2. Mr Hammond's family – via [redacted]

I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

I may also send a copy of your response to any other person who I believe may find it useful or of interest.

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.

Date: 6th December 2021