## **REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

## **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS** THIS REPORT IS BEING SENT TO: Director of Community Services – Adult Social Care **Norfolk County Council County Hall** Martineau Lane Norwich NR1 2DH CORONER 1 I am JACQUELINE LAKE, Senior Coroner, for the Coroner area of NORFOLK **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. **INVESTIGATION and INQUEST** On 9 January 2015, I commenced an investigation into the death of CHRISTOPHER WATSON, AGED 53 YEARS. The investigation concluded at the end of the inquest on 31 MARCH 2015. The conclusion of the inquest was medical cause of death: 1a) Exsanguination b) Deep laceration to left forearm and short-form conclusion: Mr Watson cut his own arm and died as a result of his action. His intention at the time is not known. CIRCUMSTANCES OF THE DEATH Mr Watson lost his job about 4 years prior to his death and since then his general wellbeing deteriorated. He became isolated. A neighbour contacted Norfolk County Council Adult Social Care Department (ASC) on 9 July 2014 raising concern that Mr Watson had not been seen for some time. As telephone contact was unsuccessful ASC asked Police to carry out a welfare check and to report back to them. The Police forced entry and found Mr Watson "painfully thin, unwashed and dishevelled". The Police reported this to ASC who telephoned Mr Watson but the telephone number was unrecognised. A letter was sent to offer support and advice and stating "If you do not require any care or support please ignore this letter." No response was received and Mr Watson's file was marked "No further action" on 22 July 2014. Another neighbour became concerned at not seeing Mr Watson over Christmas and New Year and on 7 January 2015 entry was gained to Mr Watson's property. He was found dead in his bedroom. He had been dead for some weeks. **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. –
	<ol> <li>(1) There is no concern over the actions of ASC prior to the letter being sent to Mr Watson. The concern is over the contents of the letter to the effect that if the person does not require action then they are to ignore the letter and the file is then closed. No steps are taken to ensure that the person actually receives, opens and understands the letter or whether they can read for instance.</li> <li>(2) Mr Watson was clearly vulnerable from the description provided by the Police i.e. ""painfully thin, unwashed and dishevelled". Direct contact was not made with Mr Watson to ensure he understood help is available should he wish to take advantage of it. His capacity may have needed to have been assessed.</li> </ol>
6	ACTION SHOULD BE TAKEN
	In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 27 May 2015, 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.
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8	COPIES and PUBLICATION
8	I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:
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8	I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:  I have also sent it to ————————————————————————————————
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