REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** - **Nottingham City Council** **Copies are to be sent to the other interested persons, namely** - **Family** - **Nottinghamshire Healthcare NHS Foundation Trust** - **Nottingham Recovery Network** - **Framework Housing Association** - **Rebecca Hayward's GP** - **Nottingham University Hospitals NHS Trust** - **Hatzfeld Care Home**
1	**CORONER** I am Mr Gordon Clow, Assistant Coroner for the coroner area of Nottinghamshire.
2	**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.
3	**INVESTIGATION and INQUEST** On 12 January 2022 an inquest was formally opened into the death of Rebecca Hayward who died on 13 August 2021. The investigation concluded at the end of the inquest on 13 October 2022. The conclusion of the inquest was the short form conclusion that Rebecca Hayward's death was alcohol and drug related.
4	**CIRCUMSTANCES OF THE DEATH** Rebecca Hayward had a history of substance addiction throughout her adult life. She managed to achieve abstinence from alcohol and drugs from March 2020 through to March 2021. Ms Hayward's recovery from addiction was vulnerable, however, and she was assessed by her substance misuse worker to be unable to avoid relapse if she were to be homeless and accommodated in hostel accommodation. In the weeks leading up to Ms Hayward's discharge from the care home, her substance misuse worker repeatedly and consistently reminded the professionals involved in Ms Hayward's care of the need to avoid Ms Hayward being discharged to a hostel and of her view that a discharge to a hostel would result in Ms Hayward's death from substance misuse. Ms Hayward became homeless on discharge from her care placement on 31 March 2021 whereupon she was accommodated in a hotel. She was provided with hostel accommodation on 5 May 2021. As had been predicted, this led to a relapse into alcohol and, latterly, substance misuse with catastrophic consequences for Ms

	Hayward's health and personal safety. On 13 August 2021 Ms Hayward was found deceased at someone else's property following a period of alcohol and substance misuse. Ms Hayward's death was a predictable consequence of the effect upon her of becoming homeless on 31 March 2021.
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 could 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) Assessments of persons with severe and multiple disadvantage are undertaken by persons with little or no experience or specialist training in homelessness and substance misuse, resulting in inaccurate assessment and plans; (2) Where a person is about to move to a different type of accommodation, Care Act assessments are only extended to include consideration of the individual's changed care needs in their new environment if the early assessment work identifies eligible care needs in their current circumstances, with the social care provision subsequently being dependant on a re-referral and where such re-referrals are resisted; Other areas of concern existed regarding other issues but plans were in place to address these areas and so I did not have ongoing concerns of a risk of future deaths.
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 9 December 2022. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting 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 Interested Persons set out above. 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.
9	 **Mr Gordon Clow, HMAC** **13 October 2022**