REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted] Chief Executive Officer of Bournemouth Churches Housing Association (BCHA)
1	**CORONER** I am Rachael Clare Griffin, Senior Coroner, for the Coroner Area of Dorset
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 the 8th December 2022, an investigation was commenced into the death of Tarik Roger Drakes, born on the 25th November 1978. The investigation concluded at the end of the Inquest on the 14th March 2023. The Medical Cause of Death was: Ia Opiate toxicity The conclusion of the Inquest was drug related.
4	**CIRCUMSTANCES OF THE DEATH** On the 12th November 2022 the deceased, who had a history of using heroin, was found in a collapsed and unresponsive condition in his room at his place of residence which was Room 14 Dorset Lodge, 10 Suffolk Road, Bournemouth. He was taken to the Royal Bournemouth Hospital, Bournemouth where he was found to be in multi organ failure and despite treatment his condition deteriorated, and he died on the 29th November 2022.
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. During the inquest evidence was heard that:

i. Dorset Lodge is a supported housing accommodation facility with 16 rooms that provides accommodation for those who have drug and alcohol addictions. It is owned and managed by Bournemouth Churches Housing Association (BCHA) and they are contracted to provide the housing to residents by BCP Council. It is staffed Monday to Friday, between 8am to 8pm by two support workers, one covering a shift from 8am to 4pm and the other covering a shift from 12noon to 8pm. When the support staff are unavailable, agency staff will cover the support worker role. On Saturdays a support worker is present, but this is not on a contracted basis and if she is on leave there is no cover. Outside the hours of 8am to 8pm, and on weekends, when there is no support worker on site, there is a night response team who will not be on site but attend twice during the night period to conduct perimeter checks of the building. The premises is covered by CCTV, inside and outside, which can be monitored remotely.

ii. To provide support to the residents, the support workers will undertake key worker sessions which are offered weekly. When agency staff cover the shifts, when the usual support workers are covering other sites or on leave, they do not undertake key worker sessions.

iii. Entry to the premises is gained using a key fob system. Entry is monitored by staff when on site, but between 8pm and 8am, and at weekends when no staff members are on site, residents are able to let people in without any monitoring or safeguarding measures in please.

iv. Evidence was given that those at Dorset Lodge are vulnerable due to their addictions. Mr Drakes' family gave evidence that he had disclosed to them that residents were using drugs within the premises, and they described the times when staff were not present as "party time" with non-residents entering the premises. Even when staff are on duty there is no monitoring of who is in the premises, such as by a signing in and out book. Staff undertake welfare checks upon residents 3 times a day at 10.30am, 3.30pm and 7.30pm, however evidence was given that it is not clear who is present at any one time.

v. When the police attended Room 14 at Dorset Lodge on the Thursday 17th November, items of drug paraphernalia were found in the room including needles, a sharps box and a homemade pipe. The room had been insecure from 12th November when Mr Drakes was taken to hospital and there was evidence people had been in the room after that time as items had been removed from the room and residents called the Police to report concerns.

vi. Evidence was given by the family that when they attended the premises on the 14th November they tried to call the number on the front door, which was the out of hours number, and it was a

	dead line. Unless a resident allows someone entry, this would be the only route of access to Dorset Lodge by emergency services, such as the paramedics, out of staffed hours to provide care in an emergency, which could delay entry and access to treatment. vii. Mr Drakes was last seen alive on CCTV at Dorset Lodge at 0.44 hours on the 12th November. Paramedics were called at 16.07 hours that day by other residents. As this was a Saturday, and the support worker who did work some Saturdays was not working that day, there were no welfare checks undertaken upon him by staff. It is not possible to say what would have happened if he had been checked by staff or taken to hospital sooner. viii. Mr Drakes was deemed to be vulnerable by the manager at Dorset Lodge and there were professional meetings held to discuss, amongst other things, his placement and need for 24 hour support. The last of these professional meetings was held on the 10th August 2022. One was scheduled for the 9th September 2022 but no one was available and the meeting was not rescheduled prior to the 12th November. There was no follow up meeting about his needs after the meeting on the 9th September did not go ahead. 2. I have concerns with regard to the following: i. That there could be the death of a resident at Dorset Lodge under the current processes in place regarding the monitoring, supervision and safeguarding of residents at Dorset Lodge and I would request that consideration is given to reviewing the current levels of staffing and supervision at the placement, and the processes and procedures in place around support to the residents.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and/or your organisation 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, 10th May 2023. 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:

	(1) Family of Mr Drakes I am also under a duty to send the Chief Coroner a copy of your response. I have also provided a copy of this to Mr Graham Farrant, Chief Executive of BCP Council for his awareness. 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 by the Chief Coroner.	
9	**Dated** **15th March 2023**	**Signed**  **Rachael C Griffin**