REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: **L&Q Group Housing**
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
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 2nd December 2022 I commenced an investigation into the death of Sylvia Pollitt. The investigation concluded on the 16th June 2023 and the conclusion was one of **Narrative: Died from hypothermia when her request for an engineer visit when she had concerns about her boiler did not happen and non-contact with her was not escalated.** The medical cause of death was **1a) Gastro-intestinal haemorrhage; 1b) Acute Gastric Erosions; 1c) Hypothermia**
4	CIRCUMSTANCES OF THE DEATH Sylvia Pollitt was an elderly resident of a property owned by L&Q. She called them to highlight a concern with her boiler. The call was passed to Liberty who were subcontracted to provide gas services. They were unable to contact her and closed the call down, They should have escalated the situation. On 1st December 2022 Sylvia Pollitt was found in her home address 1 Seamons Walk. Post mortem examination found she had died from complications of hypothermia.
5	<u>CORONER'S CONCERNS</u> 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. –

	The inquest heard evidence that under the SLA between the Housing Association and Liberty if there is non-contact following a referral then this should be escalated back to the Housing Association so that they can carry out welfare checks and assess the position further. Carrying out of welfare checks for vulnerable adults ensures that they are safe and well. That did not happen in Mrs Pollitt's case. The evidence before the inquest was that the Housing Association had: 1. No audit system which enabled it to know if this issue of non-escalation by Liberty was a one off or a frequent issue. They had only become aware of the non-contact in this instance following Sylvia Pollitt's death. 2. No system where they captured/monitored the outcome of each referral to their subcontractor e.g. non-contact; successful attendance.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe 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 13th September 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 namely [redacted] on behalf of the Family, who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. 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	**Alison Mutch** **HM Senior Coroner**  **19.07.2023**