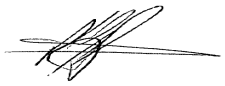
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT DATED 31 OCTOBER 2023 IS BEING SENT TO:** **Chief Executive – Devon County Council**
1	**CORONER** I am Philip SPINNEY, HM Senior Coroner, for the coroner area of Exeter and Greater Devon.
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 15 April 2021 an investigation was commenced into the death of **Eric Sebastian Huber**. The investigation concluded at the end of the inquest held on 10 October 2023. The conclusion of the inquest was as follows: *Eric Sebastian Huber was known to suffer with his mental health and was considered to be vulnerable. On 1 April 2021 Mr Huber was discovered deceased hanging [redacted]. He died due to self-inflicted suspension [redacted]* *Eric Sebastian Huber died as a consequence of his own actions.*
4	**CIRCUMSTANCES OF THE DEATH** Mr Huber had a long history of drug and alcohol use dating back to 2005. – he also had a long history of depression and anxiety. He had been managed intermittently by the community mental health services. Mr Huber was considered vulnerable and at risk of exploitation and harm from others – he was known to the safeguarding team at Devon County Council (DCC) and the safeguarding team at Devon and Cornwall Police. His vulnerability was felt to be due to alcohol, chronic mental health problems general self-neglect and to his ongoing misuse of drugs and risk of "cuckooing" from convicted drug dealers. In October 2019 a safeguarding enquiry was commenced and allocated to a case worker at DCC to follow up with a visit to establish their views and risks and discuss with the police. The case worker spoke with police officer who had seen Mr Huber that day – the officer reported that Mr Huber was fine, he was attending AA meetings regularly and coping much better – the case worker did not follow up directly with Mr Huber and did not assess Mr Huber.

	In September 2020 there was a further safeguarding concern raised to DCC by the police as his flat was being used to sell drugs by two individuals staying there – an activity known as cuckooing. The police requested a review of Mr Huber's care and support needs. On 13 October 2020 this was allocated to the same caseworker as previously. On 18 October 2020 Further concerns were raised with DCC around 2 individuals intimidating Mr Huber. There is no written record in the DCC care first record system of action taken by the case worker in response to these concerns. From the records it appears that there is no evidence of a Care Act assessment, multi-agency discussion meeting or consideration or Mr Huber's situation and how to manage the risk from drug dealers at this stage. On 24 November 2020 Mr Huber himself called the DCC Adult Social Care Direct via its call centre to ask for support – there is no record of this message being followed up by the team manager or the social worker. On 3 December 2020 a friend of Mr Huber rang DCC Adult Social Care Direct to raise concerns over cuckooing and bullying of Mr Huber and that he was struggling to cope. The case worker called Mr Huber on 7 December 2020 and discussed help with his drug and alcohol use and enabler assist to help with household matters – the case worker noted that he would contact the police for an update. There is no record of a call to the police. On 8 December 2020 the safeguarding enquiry was closed with the outcome that the immediate risks were adequately addressed and that it was a proportionate response to reallocate for a full assessment of needs. There is no record of that full assessment taking place. On 15 January 2021 a police report was received by Devon Adult Social Care Direct call-centre there are no records of any contacts or discussions arising from this police contact. The case was closed on 3 March 2021 – at this time there had been no assessment of his needs.
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) The evidence shows that there were opportunities to engage with Mr Huber and fully assess his risk and needs, these were not taken; in addition, multi-agency and multi-disciplinary discussions to consider Mr Huber's situation and how organisations could work together to address the concerns and risks were not conducted.

6	**ACTION SHOULD BE TAKEN** (1) **Consideration should be given to reviewing the processes of DCC Adult Social Care to review how referrals are triaged, allocated and actioned and how outcomes are recorded, monitored and reviewed.** In my opinion action should be taken to prevent future deaths and I believe you and 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, namely by 29th December 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 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	**SIGNED:**  **Mr Philip C Spinney** **HM Senior Coroner**