ANNEX A

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.** Torbay and South Devon NHS Trust **2.** The Disclosure and Barring Service
1	**CORONER** I am Deborah Archer , Assistant coroner, for the Coroner area of Plymouth and South West 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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 12th November 2021 I commenced an investigation into the death of Adrian Stuart Green age 55 . The investigation concluded at the end of the inquest on 23rd February 2024. The conclusion of the inquest was a narrative one in that Mr Green died at Torbay hospital on 1st November 2021 from alcoholic liver disease where opportunities to prevent his medical deterioration were not taken . Mr Green lived at Whitley court from 4th November 2019 to 26th October 2021 . Mr Green was supposed to be having assistance by way of a care package with medication , support and care , meals and shopping . Although this case was originally reported to the CQC they declined to prepare a report because they said that this was not a case that fell under their jurisdiction because Mr Green did not receive "personal care" . [REDACTED] Manager from Care First disputed that at inquest . Concerns were raised by a neighbour who had not seen activity in Mr Green's flat for a while and the housing provider notified Care support who ran the accommodation at their time of this incident . Care Support had won the contract for Devon during the pandemic and [REDACTED] had been asking the Devon service from London whether or not there were any issues with staffing or them coping during the pandemic and she was being told that there was not . On 15th October 2021 the previous manager of Whitley court and a number of staff members left the employment of Care support in an unplanned way , deleting records and electronic information as they went . This left the service in chaos and Mr Green was not receiving any sort of appropriate care or visits from about 1.10.21 . Many visits were carried out by intercom calls only which were against company policy. The service was run by agency workers who had no direction and guidance and Mr Green was left lying in squalid and unhygienic conditions in an almost unresponsive state from 23rd October 2021 to 26th October 2021 when [REDACTED] found him having arrived from London the previous day and called paramedics. Mr Green was conveyed to Torbay hospital but sadly passed away on 1st November 2021 with his family being told that if he had received medical attention sooner he would have had a 50 % chance of surviving . [REDACTED] raised a safeguarding alert to the Police and the Trust and made a referral to the Disclosure and Barring service

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) Despite there being a safeguarding meeting following Mr. Green's death on 22nd January 2022 there appeared to be no review of whether the local authority ought to be have had policies in place to ensure that independent providers were adequately carrying out their contractual duties towards vulnerable individuals especially if the CQC were correct and there was no role for them in this case (2) [redacted] gave evidence to the inquest that she believed that there was a role for the CQC here as she believed that Mr Green had been in receipt of a personal care package (3) [redacted] made a referral to the Disclosure and Barring service in respect of the former manager's actions and received no response as to what action if any the service were taking or an acknowledgement of her concerns .
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 30th April 2024 . 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 – [redacted] . I have also sent it to the Care Quality Commission who may find it useful or of interest. 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	**28th February 2024** **Deborah Archer .**