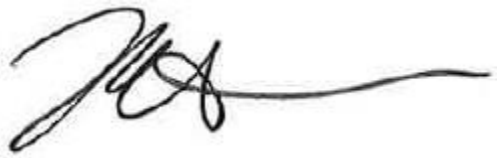
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*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], Service Manager, BCP Council, Civic Centre, Bourne Avenue, Bournemouth, Dorset**
1	**CORONER** I am Brendan Joseph Allen, Area 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 11th February 2022, an investigation was commenced into the death of Neville Stephen Abbott, born on the 7th January 1945. The investigation concluded at the end of the Inquest on the 19th April 2024. The Medical Cause of Death was: 1a Unascertained due to decompositional change 1b 1c 2 The conclusion of the Inquest recorded that Neville Stephen Abbott died as a consequence of natural causes where the precise medical cause of death could not be ascertained.
4	**CIRCUMSTANCES OF THE DEATH** Neville Stephen Abbott lived alone at 8 Puddletown Crescent, Poole. Mr Abbott was diagnosed with schizophrenia. On 7th September 2021, following a fall and

	head injury, Mr Abbott was admitted to Poole Hospital where investigations revealed a new diagnosis of atrial fibrillation. On 8th February 2022 Mr Abbott was found deceased at his home address. A police investigation revealed no suspicious circumstances surrounding his death and no evidence that alcohol, medications or other substances had caused or contributed to his death. A post mortem examination did not reveal a medical cause of death, but did exclude traumatic injury. Mr Abbott was known both to Adult Social Care ("ASC") and Community Mental Health Services. Following the diagnosis of atrial fibrillation, which placed Mr Abbott at increased risk of death from stroke, he was advised to take a direct oral anticoagulant to reduce the risk of a stroke. He declined to take the medication when advised to do so by a treating hospital doctor, and further declined following a subsequent GP home visit. He was therefore at risk of self-neglect.
5	**<u>CORONER'S CONCERNS</u>** The **MATTERS OF CONCERN** are as follows: 1. During the inquest evidence was heard that: i. The Safeguarding Adults Procedure for BCP Council contains a "Professionals Checklist" to assist with the identification of adults that are at risk of self-neglect. The check-box questionnaire identifies key questions for consideration, including whether a person is declining prescribed medication, and mandates that "consideration must be given to instigating a Multi-Agency Risk Management Meeting Self-Neglect" if there is the potential for self-neglect. The document was not used by the ASC practitioners that had contact with Mr Abbott, despite a cause

	for concern being raised by the treating hospital doctor following the Poole Hospital admission on 7th September 2021, when Mr Abbott declined medication for atrial fibrillation. No Multi-Agency Risk Management Meeting ("MARM") was called for Mr Abbott. All current and former ASC practitioners that gave evidence at the Inquest agreed that the "Professionals Checklist" is a useful document that, if used to assess Mr Abbott would have resulted in the consideration of calling a MARM and that, likely, a MARM would have been called. However, the evidence from the same witnesses was that the form was little, if ever, used at the time Mr Abbott was known to ASC. In addition, little seems to have changed: the form remains little, if ever, used. 2. I have concerns with regard to the following: i. The lack of knowledge of, and use of the "Professionals Checklist" by ASC practitioners risks adults known to ASC not being assessed where there is a potential risk of self-neglect, including the perhaps less obvious aspects of self-neglect such as declining prescribed medication. Consequently, the requirement to consider calling a MARM, mandated by the "Professional Checklist", in order to share information, assess risk and to formulate a plan to mitigate risk, may be missed.
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, by 28th June 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: (1) Leigh Day Solicitors, representing [redacted], Neville Stephen Abbott's daughter (2) [redacted]; (3) Clyde and Co Solicitors, representing BCP Council; (4) DAC Beachcroft Solicitors, representing Dorset Healthcare University Foundation Trust 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	**Dated** 3rd May 2024	**Signed**  **Brendan J Allen**