The Office of Tom Osborne
Her Majesty's Assistant Coroner for Gloucestershire
Tel: 01452 305661
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19th September 2013

[redacted]
Camp Village Trust
The Kingfisher Offices
9 Saville Street
Malton
North Yorkshire
YO17 7LL

Dear Sir,

Re: Regulation 28 Report to Prevent Future Deaths

I am Mr Tom Osborne, Assistant Coroner, for the Coroner Area of Gloucestershire and 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.

On the 26th June 2012 I commenced an investigation into the death of Daniel Onley, aged thirty five. The investigation concluded at the end of the inquest on the 29th August 2012. The conclusion of the inquest was:

> Cause of death: Sudden unexpected death in epilepsy
> Conclusion: Natural Causes

Daniel Onley had been a resident at Orchard House, Grange Village Littledean in Gloucestershire, since 1999 his care being provided by the Camphill Village Trust. At about 8.00 am on the morning of the 22nd of June 2012 a carer entered Daniel's accommodation and found him face down in the bath. A subsequent post mortem examination concluded that he had died from "sudden unexplained death in epilepsy".

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) That the arrangements in place to support Daniel to take his anti-convulsant medication were insufficient.

(2)There had been a failure to manage risks associated with Daniel's management of his medication.

(3) The supervision provided to Daniel during the evening of Thursday 21st June 2012 was not sufficient to safeguard Daniel's safety and wellbeing.

In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action following, perhaps, a review of the care arrangements at the care community.

You are under a duty to respond to this report within 56 days of the date of this report, namely by Thursday 14th November. 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.

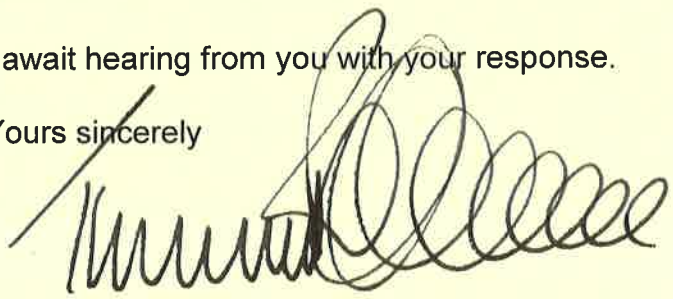
I have sent a copy of my report to the Chief Coroner and to the properly interested Persons listed at the foot of this report. I have also sent it to the Care Quality Commission and Gloucestershire Social Services who may find it useful or of interest.

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.

I await hearing from you with your response.

Yours sincerely



Tom Osborne
Assistant Coroner for Gloucestershire

This report is being sent to:

- Family

- Chief Coroner
- Care Quality Commission
- Gloucestershire Social Services