REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28: REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:-** **1. Ms Katrina Percy, Chief Executive, Southern Health NHS Foundation Trust.**
1.	**CORONER** I am Mr D M Salter, HM Senior Coroner for Oxfordshire.
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 8 July 2013, I opened an Inquest into the death of Connor Sparrowhawk, aged 18, at the Short Term Assessment and Treatment Unit (STATT), Slade House, Oxford. As you will know, a Jury Inquest commenced on 5 October and concluded on Friday 16 October.
4.	**CIRCUMSTANCES OF THE DEATH** The Jury concluded as follows:- *Connor Sparrowhawk died on 4 July 2013 at STATT. No cardiac activity detected and CPR being carried out, with death pronounced at the John Radcliffe Hospital. Connor Sparrowhawk died by drowning following an epileptic seizure while in the bath, contributed to by neglect.* You will be aware that the Jury also outlined further findings and failings.
5.	**CORONER'S CONCERNS** During the course of the Inquest the evidence revealed matters giving rise to a 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 make this report to you. I place on record however the fact that significant steps and improvements have already been introduced following Connor's death. There was evidence of this from [redacted] and in the documentation that was provided. The remaining **MATTERS OF CONCERN** are as follows:- 1) It appears that the current recommendation at the Trust is for patients with epilepsy to be able to choose to bath but to be the subject of sight/sound observations. There are obviously difficulties in respect of patient dignity with observations by sight. As far as observations by sound are concerned, it is envisaged that a member of staff will be sat outside the bathroom door while the patient takes a bath. I am concerned however that observations by sound alone may not prevent someone from drowning. A person can drown in seconds if they are rendered unconscious by an epileptic fit. It also seems to me that a member of staff in, for example, the corridor is likely to be distracted by other members of staff and patients and may also have an occasional requirement to obtain a drink or use the toilet etc. In reality, on a busy ward,

	particularly with a patient who has reasonably well controlled epilepsy, the concern is that close observation by sight/sound is unlikely to be maintained. I am concerned that this policy is simply setting the Trust up to fail. I understand that a decision was taken sometime after Connor's death to stop bathing. I also understand however that the CQC when they carried out one of their inspections was critical of this decision due to the fact that the CQC are not in favour of blanket bans of this nature. I am sending a copy of this letter to the CQC for them to comment on. My concern is therefore in relation to the effectiveness of bath time observations for patients with epilepsy. 2) The second matter of concern is in relation to RIO and the fact that there does not appear to be an appropriate prompt or place to record details about a patient's epilepsy/history. In Connor's case, this led to details of his epilepsy being placed on the care plan. Even though there have been improvements, including the introduction of the epilepsy tool kit, it is not clear whether, even now, all the required information about epilepsy can be captured on RIO and therefore, is easily accessible to staff.
6.	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that your organisation has the power to take such action.
7.	**YOUR RESPONSE** You are under a duty to respond to this request within 56 days of the date of this report. I may extend the period on request. 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 sent a copy of my report to the Chief Coroner and to the Interested Persons. 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, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9.	 **Monday 2 November 2015** **Mr D M Salter - HM Senior Coroner**