East London Coroners
MISS N PERSAUD
SENIOR CORONER
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
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REF:9469

3rd July 2019

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: John Brouder, Chief Executive, North East London Foundation Trust, Goodmayes Hospital, Barley Lane, Goodmayes, Ilford, Essex, IG3 8XJ**
1	**CORONER** I am Miss N Persaud Senior Coroner for **East London**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 21/01/2019 I commenced an investigation into the death of John Patrick Doyle. The investigation concluded at the end of the inquest 25th June 2019. The conclusion of the inquest was a narrative conclusion: *Mr Doyle died as a result of starvation ketoacidosis, following a likely fall in his home address. It is likely that he was unable to get up or seek assistance, following the fall. He had suffered a similar fall and long-lie, some months prior to his death. The need for a panic alarm was identified, but no alarm had been put in place at the time of his death.*
4	**CIRCUMSTANCES OF THE DEATH** Mr Doyle was admitted to hospital in July 2018 having fallen at his home address. Following the fall, he had laid undiscovered for 4 to 5 days. He was discharged from Hospital on the 10 September 2018. Prior to his discharge, there was recognition of a need for a panic alarm. A panic alarm was requested, by the occupational therapist with an urgency level of "high" on the 4 September 2018. There were initial difficulties in reaching Mr Doyle, but a home visit to arrange the alarm took place on 18 September 2018. A different type of alarm was recommended, because Mr Doyle did not have a landline. Advice was provided to the occupational therapist on how to request this, on the 27 September 2018. The occupation therapist did not lodge the request until 4 October 2018. Sadly, Mr Doyle was found deceased by a district nurse on the 3 October 2018. It is likely that he had suffered a fall and was unable to get back up or to seek assistance. He died from starvation ketoacidosis.
5	**CORONER'S CONCERNS**

	During the course of the inquest the evidence revealed a matter 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 **MATTER OF CONCERN** is the evidence heard around the training provided to occupational therapists in relation to the emergency equipment available from Telecare. It is requested that the training for occupational therapists is reviewed to consider: I. The emergency alarm equipment available II. The order process required for such equipment, and III. The compatibility between the alarm system and the telephone systems within the home setting. It was also noted that technology changes frequently and therefore it is requested that a form of refresher training is also considered.
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 **28th August 2019**. 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] (sister of the deceased) and to the London Borough of Barking & Dagenham. I have also sent it to Mr Matthew Cole (Director of Public Health) and to the CQC 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.
9	03/07/2019 Signature Miss N Persaud Senior Coroner **East London**