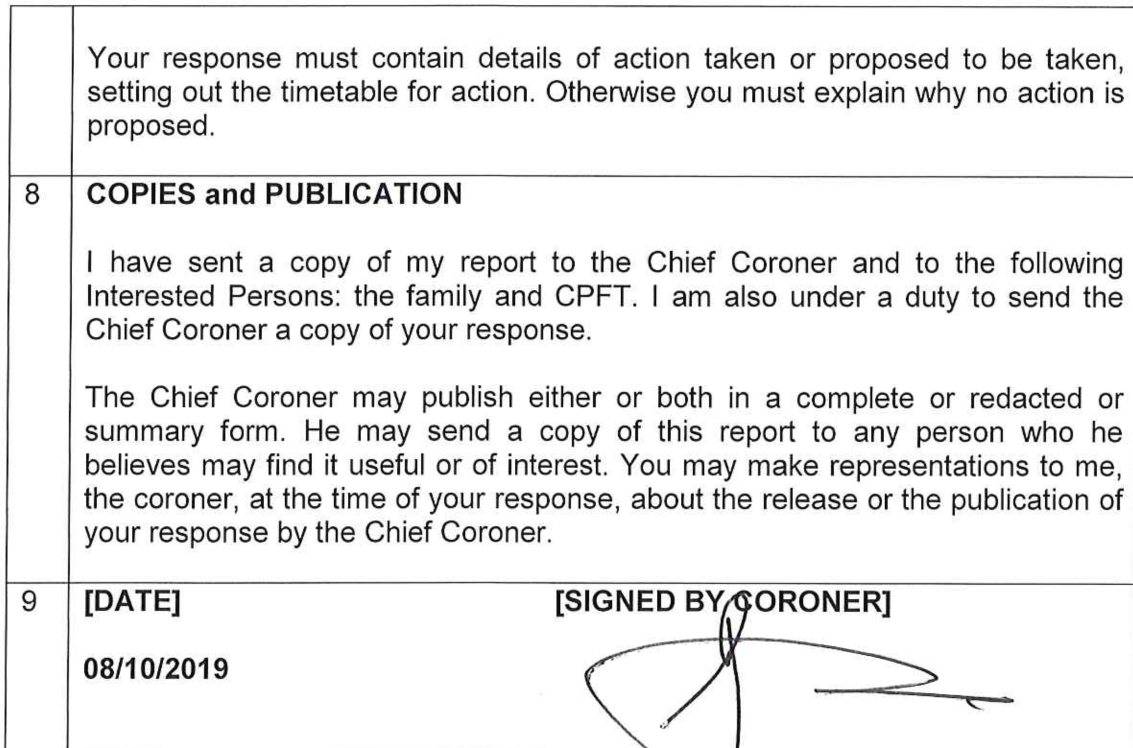
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Dylan Jay Henty, deceased

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Owner and Registered Manager of Pentree Lodge Home, 63-65 Pentire Avenue, Newquay**
1	**CORONER** I am Andrew Cox, Acting Senior Coroner for the coroner area of Cornwall and the Isles of Scilly.
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 13 March 2018, an inquest was opened into the death of Dylan Jay Henty who died on 21 February 2018. The inquest culminated in a final hearing on 19 – 20 September 2019 with an Open Conclusion being recorded. The cause of death identified at post-mortem was: 1A) multiple injuries
4	**CIRCUMSTANCES OF THE DEATH** Dylan had a complex past medical history that included schizophrenia (for which he was in receipt of prescription medication) and a cerebral tumour that had previously been debulked. He suffered with difficulties in communication. There had been some history of non-compliance with medication which included verbal aggression towards staff. On two occasions, modest amounts of prescribed medication had been found in his room. He was known to suffer from seizures and in December 2017 had suffered a seizure in the bath while unsupervised. There had been at least two previous episodes of absconding from the home in October 2017 and February 2018. There was no history of previous overdoses or of attempts to take his own life. On 17/2/18, he appeared in good humour. He attended a party for another resident and was seen to dance. Later, he declined his prescribed medication. Subsequently, he was found to be missing from his room and a report was made to police. On 21/2/18, Dylan's body washed up at the south end of Fistral beach. There is no evidence to explain the fall from height he appears to have suffered or how he came to end up in the sea.
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 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. i. While it appears to have had no bearing on the circumstances of Dylan's death, I was concerned to hear evidence of Dylan suffering a seizure in a bath while unsupervised. Similar episodes elsewhere in the country have resulted in criminal prosecutions. It is not clear to me whether reports were made to the CQC, GP and/or care coordinator. You may wish to reflect on the need for clear guidance and training to all staff on the arrangements for those residents with a known risk of seizure to take baths (as opposed to showers) where there is an obvious risk of drowning should a seizure occur. Similarly, those in management positions must be clear about the circumstances in which formal reports should be submitted to relevant bodies and you may feel there is a need to ensure these standards are rigorously checked and met. ii. Dylan's GP was unaware of previous incidents of hoarding. He felt this was something that should have been brought to his attention. You may wish to reflect on the need for clear guidance and training to all staff in such matters. Similarly, you may wish to reflect on the need for those in management positions to ensure rigorous compliance with the relevant standards. iii. Linked to the issue of hoarding is the question of how to ensure a resident is compliant with taking medication prescribed to him. It was accepted in evidence that, given the discovery of the medication in Dylan's room, the system in place must have failed. It was recognised in court that there are limits to enforcing residents to take medication. Nevertheless, there needs to be a robust system in place and where there is doubt about a resident's compliance, notification should be made to the relevant professionals iv. There appeared to have been inconsistency in the reporting of incidents of absconding. You may wish to reflect on the need, in similar circumstances, for reports to be made to the GP, care coordinator and CQC. Further, you may wish to consider at what point there is a need for such matters to be considered at MDT level, for example, to consider whether current residential arrangements continue to be appropriate. v. Linked to the above are the arrangements put in place to monitor residents where there have been previous incidents of absconding. There needs to be a clear recognition of what is realistic particularly when set against the desire to ensure the Lodge remains the resident's home.
6	**ACTION SHOULD BE TAKEN** In my opinion 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, namely by 20/11/2019. 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: the family and CPFT. 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	**[DATE]** **[SIGNED BY CORONER]** **08/10/2019**