REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Dame Sally Davies, The Chief Medical Officer for England** **2. [redacted] President of The Royal College of Psychiatrists** **3. [redacted] Chair of Council, The Royal College of General Practitioners** **4. [redacted] President of The Royal College of Physicians** **5. [redacted] President of The Royal College of Paediatrics and Child Health** **6. [redacted] President of The British Psychological Society** **7. [redacted] President of The Royal College of Speech and Language Therapists** **8. Caroline Stevens, the Chief Executive of the National Autistic Society (NAS)**
1	**CORONER** I am Dr Elizabeth Didcock, Assistant Coroner, for the coroner area of Nottinghamshire
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 1st September 2016 I commenced an investigation into the death of James Frankish. The investigation concluded at the end of the inquest on 31st October 2017.The conclusion of the inquest was a Narrative as follows: James Frankish died on the 29th August 2016, following a sudden collapse at Beeches Residential Home. James was the subject of a Deprivation of Liberty Safeguard Order at the time of his death. James had severe autism and a learning disability and was diagnosed with Pica at the age of three, and regularly ate indigestible objects, particularly plant material. In the last few months of his life, James was apparently well. On the evening prior to his death, James vomited plant material, and expelled a hard plant mass (a phytobezoar) from his stomach into his oesophagus, causing sudden obstruction and he died shortly thereafter. James's Pica and eating behaviours were not fully understood, nor managed, by staff that had care of him at Beeches.
4	**CIRCUMSTANCES OF THE DEATH** James was aged 21 when he died. He had severe autism, severe Intellectual Disability and Pica- a condition where individuals persistently eat non-nutritive substances. James was a highly complex and vulnerable young man. He was very well understood by his parents, [redacted] who understood that he was compulsive in his Pica behaviour, and would take any opportunity to grab and eat all kinds of things, but particularly plants and leaves. By contrast, none of the professionals involved in James's care fully understood the severity and extent of his Pica, nor appreciated it was a life threatening condition. James had required specialist education throughout his childhood. He was non-verbal, but those who knew him could understand and interpret his communications. He was diagnosed with autism and with Pica around the age of 3. His Pica behaviour had included many different objects over the years, and he was very quick to eat and

	swallow. He was seen by many different professionals over the years, and did not appear to have any symptoms from the developing phytobezoar. By the time of his death this accumulation of hard plant material was of significant dimensions 20x10x5cm. James moved to the Beeches in April 2016. The staff who cared for him there were aware that James had Pica, but did not understand the significance of it, the risk it posed, and particularly the need for constant monitoring and management of the condition. On the day of his death James ate a significant amount of green leaf material. This together with the longstanding phytobezoar likely irritated the stomach lining, inducing vomiting and then oesophageal obstruction, from the vomited bolus of plant material. Cambian Adult Services who were the provider of The Beeches residential home, completed a full review of the circumstances of James death, and submitted additional statements following the Hearing that demonstrated significant learning, and improvements. This went some way to addressing concerns raised in evidence. In my view, however, there remain outstanding concerns that allow for the continuation of circumstances creating a risk that other deaths will occur if such matters are not addressed. Further detail regarding the circumstances of James sad death are included in the attached judgment.
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. – (1) Professionals who cared for James did not understand how dangerous Pica can be, ie that it carries significant health risks, including the development of a bezoar. This included the GP, Paediatrician, Psychiatrist, Speech and language therapist, Clinical Psychologist. (2) That there is no national or professional guidance about identification, assessment and management of Pica, with no guidance about how best to understand and manage risk in this condition (3) That there is no national or professional guidance for monitoring for the possible development of a bezoar in an individual who has Pica.
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 5th December 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. For the avoidance of doubt, I will require a response from all the Royal Colleges and the NAS to point 1) above. In my view awareness raising of this condition is necessary across all disciplines. I require a response from the Chief Medical Officer to

	points 2) and 3) above, however, respondents are at liberty and encouraged to respond to all of the issues raised. Respondents may consider it advantageous to consider some of these issues jointly as well as individually. Should respondents favour supplementing their individual responses with a joint response, such a collaborative approach would be greatly welcomed but there is of course no obligation to do so.
8	***COPIES and PUBLICATION*** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted] James parents, Next of Kin) 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	**9th October 2019** **Dr E A Didcock**