REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Head of the Adult and Community Services** **Suffolk County Council** **Endeavour House** **8 Russell Road** **Ipswich** **IP1 2BX** **The Chief Executive Norfolk and Suffolk NHS Foundation Trust,** **Trust Headquarters** **Hellesdon Hospital** **Drayton High Road** **Norwich** **NR6 5BE.**
1	**CORONER** I am Nigel Parsley, Senior Coroner, for the coroner area of Suffolk.
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 3rd August 2017 I commenced an investigation into the death of **Darren Edward KING** The investigation concluded at the end of the inquest on 24th February 2020. The conclusion of the inquest was that the death was the result of:- **Darren King died as the result of an accidental death following an epileptic seizure whilst in his bath.** The medical cause of death was confirmed as: **1a Drowning** **1b Epileptic seizure**
4	CIRCUMSTANCES OF THE DEATH Darren King died on or before the 8th April 2017 at his home address of [redacted] Dell Road East, Lowestoft in Suffolk. When found by his mother, late on the 8th April 2017, Darren was unresponsive with his head under the water in the bath. Darren had a known history of epilepsy, autism and learning difficulties. Following his death, a post-mortem examination concluded that Darren's medical cause of death was drowning as the result of an epileptic fit.

	At the time of his death Darren was under the care of Suffolk County Council Adult and Community Services, the Norfolk and Suffolk Foundation Trust and his local General Practitioner. Because of the complexity of Darren's case he was on a multi-disciplinary/agency CPA (Care Plan Approach) the management of which was undertaken by a care co-ordinator. When the CPA was commenced, it was documented that the agencies involved were aware of the significant risk bathing posed to Darren, due to his epilepsy. Darren had an identified poor record for attending both medical and social care meetings, however his poor attendance increased after June 2016. This increased lack of engagement appeared to have coincided with staff changes and a new management responsibility for a newly designated care co-ordinator. The last contact his care coordinator from the Norfolk and Suffolk Foundation Trust had in person with Darren was in June 2016. In September 2016 Darren saw his GP. At this time Darren was having seizures up to three times a week (previously Darren had suffered from these approximately three times per month). Darren's epilepsy medication was increased, and he was told he needed a further epilepsy treatment review in three weeks time. This was the last reported contact with a medical or mental health professional regarding Darren's epilepsy treatment plan and, although seen by support workers from other CPA agencies, there was no further contact made with him by medical or mental health professionals in the 6 months leading up to his death. As a result of this lack of contact, there was no opportunity to review Darren's epilepsy treatment regime and no opportunity to effectively monitor his seizure history. On a balance of probability basis had opportunities to provide adequate monitoring and treatment relating to Darren's epilepsy been taken, then his death may have been prevented.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you; the **MATTERS OF CONCERN** as follows. – **In Darren's case it was clear that due to his learning disability and autism, engagement with him could be difficult.** **However, the following three areas of concern were identified.** **1. The lack of effective follow up action when a patient with learning disabilities disengages, especially when they are a high-risk patient (such as Darren).** **2. The lack of a clear escalation process when an increased risk is identified and this risk cannot be easily addressed (as it was in Darren's case).**

	3. The lack of a structured medication review as part of the overall Care Plan Approach so that staff from all agencies involved are aware of the importance of medication compliance and understand the referral/escalation routes should they have a concern.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 2nd June 2020 I, the Senior Coroner, may extend the period if I consider it reasonable to do so. 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; Darren's family and [redacted] GP. I am 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Nigel Parsley 6th April 2019**