REGULATION 28: REPORT TO PREVENT FUTURE DEATHS.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • The Rt Hon Nadhim Zahawi MP, Secretary of State for Education Copied for interest to: • Chief Coroner • The Rt Hon Sajid Javid MP, Secretary of State for Health and Social Care • [redacted] • Dr [redacted] • Dr [redacted] • Dr [redacted] • Manchester City Council • Salford City Council • Manchester Safeguarding Partnership • Loreto High School • Manchester University NHS Foundation Trust • The Newcastle upon Tyne Hospital NHS Foundation Trust
1	**CORONER** I am Mr Zak Golombeck, Area Coroner for Manchester (City) Area
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	**INQUEST** I concluded the inquest into the death of Adrian Vincent Balog on 21st February 2022. I recorded the following medical cause of death: 1a. Multiorgan failure 1b. Dilated cardiomyopathy 2. Morbid obesity; Heparin induced thrombocytopenia I returned the following narrative conclusion: The Deceased died from natural causes contributed to by his longstanding morbid obesity, which itself significantly contributed to his death in that it rendered him ineligible to receive appropriate treatment. Those parentally responsible for him did not educate the Deceased on the correct foods to eat nor on how to live a healthy

	lifestyle, and did not take him to (or access support from) weight management services. Throughout his childhood he was fed an unhealthy diet and allowed to continue with this diet into his early teenage years.
4	**CIRCUMSTANCES OF THE DEATH** The Deceased was 13 years of age at the time of his death. He had suffered from morbid obesity from the age of 3. In February 2015 he was diagnosed with dilated cardiomyopathy. As a result of his morbid obesity, the Deceased was not eligible to undergo heart transplantation, or any interim measures pending transplantation for his weight to reduce to a transplantable level. The Deceased was hospitalised in February 2015 and was diagnosed with heparin induced thrombocytopenia which was a further factor in the Deceased not being eligible for interim measures, including mechanical support of his heart. The Deceased was transferred from Royal Manchester Children's Hospital (RMCH) to Freeman Hospital, Newcastle, on 15th March 2015 for consideration of treatment options. No treatment options were viable, and therefore the Deceased returned to RMCH on 18th March 2015 and a decision was made for him to receive palliative care. The Deceased died on 2nd April 2015 at RMCH. The Inquest explored evidence in relation to the Deceased's clinical care, and also matters relating to public health concerns in view of the Deceased's morbid obesity, and whether this should have led to a referral to children's services by clinicians in primary care and/or staff at the Deceased's school. Evidence was admitted which pointed to a change in societal attitudes and mores towards childhood obesity since 2015, although it was accepted by the public health witnesses that there is progress to be made for obesity to be afforded the same level of concern as malnourishment in children. It was accepted that an obese child – and particularly a morbidly obese child – may be a child at risk, even in the absence of other signs of neglect.
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 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: Two Department for Education documents referred to in evidence, namely 'Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children' (July 2018) and 'Keeping children safe in education 2021: Statutory guidance for schools and colleges' (September 2021) were referred to in evidence. I admitted oral evidence from the current Headteacher of Loreto High School (the school the Deceased attended), [redacted], who told the court

	that the school's recent policies on safeguarding adopted the information from these government documents. In the two government documents there is no reference to 'obesity' relating to signs and symptoms of neglect in children. The absence of such a reference is a matter of concern as to how obesity in children is viewed as a public health issue in comparison to malnourished or underweight children (which are both referenced as signs and symptoms of neglect). The consensus from the public health witnesses was that obesity should be included within national guidance as a sign of symptom of neglect in order to protect children at risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 20 April 2022. 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 Interested Persons. I have also sent it to organisations 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	**DATE:** **NAME OF CORONER:** 23 February 2022 **Zak Golombeck** HM **Area** Coroner for Manchester City Area **Signed:**