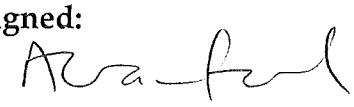
IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Rebecca Gilbank
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • [redacted], Medical Director and Co-Founder of Independence Homes Limited.
1	**CORONER** Ms Anna Crawford, HM Assistant Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	**INVESTIGATION and INQUEST** The inquest into the death of **Ms Gilbank** was opened on the 14th May 2015 and was resumed and concluded on the 12th July 2016. The cause of death was: 1a – Sudden Unexpected Death in Epilepsy (SUDEP) The conclusion was 'Natural Causes'.
4	**CIRCUMSTANCES OF THE DEATH** Ms Gilbank was a 25 year old woman who suffered from severe myoclonic epilepsy and had significant learning difficulties. She required assistance with all aspects of her daily life. She resided at Clareville Lodge in Caterham, which is owned and managed by Independence Homes Ltd. Clareville Lodge provides a supported living and domiciliary care service to individuals with epilepsy and other complex needs, including learning difficulties. Following a request by her mother in January 2015 it was agreed that Ms Gilbank would be checked on every half an hour. On the night of 11/12 May 2015 there were two waking night staff on

	duty. At 2am one member of staff found Ms Gilbank unresponsive in her bed. She called her colleague and they could not find any sign of breathing. A member of staff then tried to call emergency services from the office landline but was unable to obtain an outside line. She therefore used her personal mobile phone and began CPR until the arrival of the paramedics. Efforts to resuscitate her were unsuccessful and she was pronounced dead at 2.59am.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed the following: The **MATTERS OF CONCERN** are: <u>Lack of check at 1.30am on 12 May 2015</u> Evidence at inquest revealed that the check was not carried out because the two members of waking night staff were busy dealing with other service users. The court heard evidence that this was not an isolated occurrence and that checks had been missed on other occasions in circumstances in which staff were dealing with other service users. Consideration should be given to providing sufficient staff resources to ensure that staff are able to carry out the relevant checks at the times required. <u>Lack of knowledge about how to obtain an outside telephone line</u> Evidence at the inquest revealed that the staff on duty did not know how to obtain an outside line to call emergency services and, after trying, had to rely on a personal mobile phone. This resulted in a delay of unknown duration. Consideration should be given to providing clear and accessible guidance to all staff, including staff who do not work at Clareville Lodge on a regular basis, to ensure that they are aware of how to obtain an outside line in the event of an emergency.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to the following: 1. [redacted] 2. [redacted] 3. Havering Clinical Commissioning Group 4. Care Quality Commission 5. The Chief Coroner
	Signed:  **DATED this 26th July 2016**