East London Coroners
MISS N PERSAUD
SENIOR CORONER
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
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REF: 109767

23 September 2020

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Chief Executive, Disclosure and Barring Service, PO Box 3961, Wotton Bassett, Swindon, SN4 4HF
1	**CORONER** I am Nadia Persaud Senior Coroner for **East London**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 17th December 2018, I commenced an investigation into the death of Mrs Jane Jowers. The investigation concluded at the end of the Inquest on the 17th September 2020. The conclusion of the Inquest was a narrative conclusion: *Mrs Jowers was a resident in a Care Home. On the 21 October 2018 she did not receive her required anti-seizure medication. She suffered a seizure on the 22 October 2018 and required admission to hospital. She was taken to hospital by ambulance. In hospital she continued to have some seizure activity and was diagnosed with sepsis. A fracture of her hip was discovered on the 25 October 2018. It is not known how or when the fracture occurred, but minimal trauma is likely. Her health continued to deteriorate and she passed away in St Francis Hospice on 23 November 2018. The seizures, caused* mainly by the omission of her medication, set off a chain of events that contributed to her death.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Jowers was a 68 year old lady who was suffering from advanced Alzheimer's dementia. She had early onset dementia from around the age of 58 and by 2018 was bed bound. She was fully reliant on carers for the administration of her medication. On the 21st October 2018 a senior carer employed within her care home failed to administer her anti-epileptic medication. Mrs Jowers suffered a seizure the following day which resulted in her admission to hospital. Her health declined considerably following this seizure and she passed away in a hospice on the 23rd November 2018.

	During the course of the investigation, it was discovered that the senior carer who omitted to administer her medication on the 21st October 2018 had previously resided in the Republic of Ireland. He had prior criminal convictions including two convictions for assault. From 2013 he had worked in a number of care homes in the UK. He had received a clear enhanced DBS check prior to commencing his periods of employment. The evidence given in Court from the witness was that he believed that he did not need to disclose his prior convictions as these had not come up on the DBS checks. Had the Care Home been aware of the convictions, he would not have been employed to provide care to vulnerable adults.
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. – The evidence at the Inquest revealed that there is no statutory procedure for checks to be undertaken for criminal convictions outside of the UK. The absence of statutory international checks may result in unsuitable persons with prior convictions working with vulnerable adults and children.

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 **17th November 2020**. 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, to the family of the deceased and other interested persons to the Inquest. I will also send a copy of the report to the Director of Public and to the CQC. 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	23/09/2020 Signature  **Ms Nadia Persaud Senior Coroner East London**