Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This from is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:
[redacted], Head of Health Improvement, NHS Suffolk, Suffolk County Council, Ipswich

1 CORONER

I am Jacqueline Devonish, Area 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 25/02/2016 00:00 Dr Peter Dean commenced an investigation into the death of Justin John BROWN aged 43.

The investigation concluded at the end of the inquest held by me on 22 March 2019. The conclusion of the inquest was that Justin Brown died from ketoacidosis due to diabetes and chronic alcohol abuse, with underlying conditions of chronic pancreatitis and bronchopneumonia.

The jury returned a narrative conclusion finding that the condition causing the death had been developed through poorly controlled insulin administration by Mr Brown. His past medical history suggested a previous episode of ketoacidosis resulting in a hospital admission between 27 December 2015 and 4 January 2016. Upon discharge he had been warned that a relapse could be fatal upon consuming excessive amounts of alcohol combined with poor insulin control.

4 CIRCUMSTANCES OF THE DEATH

On 18 February 2016 at 22:19 welfare call was made to the police by Mr Brown's sister who resided in London. Justin Brown resided in Suffolk. The information was passed from the Metropolitan police to Suffolk police who attended the address at 00:37 but got no response from the communal intercom and therefore left without making contact. The police returned to the address on 19 February at 12:18 and found Mr Brown deceased. Life was recognised as extinct by the ambulance service at 12:40.

Mr Brown's history included periods of support in rehabilitation and the incident referred to on 27 December when he had been admitted to James Paget University Hospital (JPUH) in a life-threatening condition. Upon discharge he was referred to Turning Point, the Drug and Alcohol Service, which was at that time the only drug service available in the Suffolk area for referrals from JPUH. There was no direct means of communication with the service. In evidence, the court heard that the process for referrals was by a telephone message to an answerphone. There was no acknowledgement or confirmation of service user contact. When supported Justin Brown was able to remain compliant for extended periods. Upon discharge he was keen to remain well.

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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you;

Justin Brown had been discharged from hospital without confirmed support for his addiction between 4 January and his death on 19 February 2019. In light of his history of cooperation with the service the hospital would have been assisted by an agreed protocol and closer working with the commissioned drug service to enable monitoring of referrals sent and outcomes for the service users.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/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 May 22, 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.

8 COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons

James Paget University Hospital and [REDACTED]

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.

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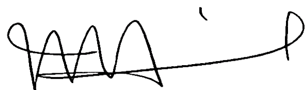

Jacqueline DEVONISH
Area Coroner for
Suffolk
Dated: 27/03/2019