REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. St Edwards School, Sherfield English nr Romsey Hampshire.**
1	**CORONER** I am Sarah Whitby, assistant coroner for the coroner area of Southampton and The New Forest.
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 28th May 2014 I commenced an investigation into the death of Daniel Stickland aged 17. The investigation concluded at the end of the inquest on 13th February 2015. The conclusion of the inquest was death from natural causes; Medical cause of death: 1.a Sudden Cardiac Death with Morphologically Normal Heart 2.Epilepsy
4	**CIRCUMSTANCES OF THE DEATH** On the 14th May 2014 the deceased was found collapsed having fallen from bed at his residential school St Edwards. He had been under investigation for seizures but no diagnosis had been made. Earlier that day he had had two seizures now recognised as indicating a form of epilepsy and after the second emergency services were called but did not take him to hospital. On the information presented and in the way presented from non -medically trained school staff and from their own observations of Daniel the emergency personnel felt there was no need to do so. Daniel was taken to Southampton General Hospital where he was pronounced dead the following day.
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. – (1)Lack of a written handover between evening and night supervisors at St Edwards School (2)Movement log that was not completed accurately or with enough detail (3)Daily log that was not easily accessible and was misleading (4)No clear method of centrally and accurately recording significant medical events to

	facilitate passage of information to non -school persons.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to improve record keeping and streamline the recording of significant events, to ensure staff and outside bodies are accurately briefed in emergencies. Further action should be taken to direct responsibility for all medical matters in a proper chain of command. These actions should be taken so as to prevent future deaths and I believe your organisation has 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 the 20th April 2015. 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, [redacted] SGH and SCAS and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)]. 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	**[20 February 2015** **[SIGNED BY CORONER]**