IN THE SURREY CORONER'S COURT

IN THE MATTER OF: LUCY PATRICIA COLGATE

The Inquest Touching the Death of LUCY PATRICIA COLGATE

A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO [redacted]**, President of the Association of British Neurologists.** [redacted]**, Chief Executive of Epilepsy Action.** [redacted] **President of the Royal College of Paediatrics and Child Health**
1	**CORONER** I am Caroline Topping HM Assistant Coroner, for the coroner area of Surrey
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**

	An inquest into the death of Lucy Patricia Colgate was opened on the 12th May 2020 and resumed on the 12th January 2021. The inquest concluded on 29th January 2021. I found that the medical cause of her death was; 1a. Positional Asphyxia 1b. Uncontrolled Epilepsy I concluded with a Narrative Conclusion: Lucy Patricia Colgate suffered from generalised epilepsy which was poorly controlled on medication which had been appropriately prescribed. On the 28th March 2019 she had an epileptic fit at home and became wedged behind a door so that the door could not be opened. She was in a prone position. Paramedics attended promptly and managed to gain access to her within 20 minutes by which time she had suffered a hypoxic cardiac arrest through positional asphyxia and the effect of being in a post ictal state. She was taken by ambulance to Royal Surrey County Hospital but pronounced dead on arrival.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are detailed in the narrative conclusion.
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 could 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 showed that: 1. [redacted] who was Lucy Colgate's Consultant Neurologist gave evidence that the risks posed to epilepsy sufferers from locked doors is a recognised risk but that the risk posed by having inward opening doors to confined spaces is not widely appreciated. If the door had been outward opening Lucy Colgate is likely to have survived.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken 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 7.4 2021. 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] and Royal Surrey County Hospital I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your report to any other person who I believe may find it useful or of interest. 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	**Signed:** **Caroline Topping** **Dated this 12th February 2021.**