

# Regulation 28: REPORT TO PREVENT FUTURE DEATHS

## REGULATION 28 REPORT TO PREVENT DEATHS

### THIS REPORT IS BEING SENT TO:

1. [REDACTED]  
Jeesal Akman Care Corporation Ltd  
Jeesal Holdings Ltd  
Jeesal Residential Care Services Ltd  
16-18 High Street  
Dereham  
Norfolk  
NR19 1DR
2. Norfolk & Norwich University Hospital  
Colney Lane  
Norwich  
NR4 7UY

### 1. CORONER

I am Jacqueline LAKE, Senior Coroner for the area of Norfolk

### 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 07/08/2020 I commenced an investigation into the death of Ben Buster KING, aged 32. The investigation concluded at the end of the inquest on 09/07/2021. The medical cause of death was:

- 1a) Acute Type II Respiratory Failure
- 1b) Obesity Hypoventilation Syndrome and Use of Sedative Medication
- 1c) Obesity
- 1d) Down's Syndrome, Obstructive Sleep Apnoea

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The conclusion of the inquest was: Failure to diagnose obesity hypoventilation syndrome and inadequate consideration of the use of promethazine. Failure to identify the seriousness of a life-threatening situation.

### 4. CIRCUMSTANCES OF THE DEATH

Ben was detained under the Mental Health Act at Jeesal Cawston Park (JCP) from 2018. His medical history included Down's Syndrome, severe learning disability and sleep apnoea in respect of which he had used a CPAP machine but was not always tolerant. Ben's weight as at June 2019 was recorded at 85.2 kg which had risen to 106 kg by June 2020. Ben attended at Norfolk and Norwich University Hospital (NNUH) on 9, 10<sup>th</sup>, 12<sup>th</sup> July 2020 following respiratory problems and was discharged to JCP. At 22.00 on 28 July 2020 Ben was given [REDACTED] Promethazine, a sedative, as he was showing signs of agitation. In the early hours of 29<sup>th</sup> July 2020 Ben became unwell. At about 0700 CCTV showed Ben unresponsive. Emergency services were called at 07.07. Ben was taken to Norfolk and Norwich University Hospital where he was pronounced dead later that 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 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:

#### JCP

1. Jeetal Akman Care Corporation (Directors: [REDACTED]) was the care provider for JCP and closed in May 2021. However, Jeetal Holdings Ltd (JHL) and Jeetal Residential Care Services Ltd (JRCSL) and possibly other linked companies with the same Directors, continue to provide residential care to persons with mental health illness, learning disabilities, complex needs and physical disability. The concerns raised at the inquest could apply to residential care offered by these companies and unless such concerns are addressed there is a risk that future deaths may occur. It is not known if the Directors of these companies namely [REDACTED] are Directors of any other companies providing care for persons with learning and other disabilities
2. CCTV was shown at the inquest which revealed Ben King had been assaulted in the hours prior to his death and also that 1 to 1 observation was not carried out in accordance with the Observations Policy. CCTV is a reliable means of ensuring that staff comply with Policies and residents are treated with dignity. CCTV is not available in many if not all of the residential homes owned by JHL and JRCSL.
3. Basic dietary advice and guidance provided was not followed by staff.
4. The use of the Dietician in training of staff was reduced in 2017 from one day's training to an hour's power point presentation
5. Important records were not completed by staff, eg Food intake, Exercise, Weight and vital observations
6. Evidence was heard that exercise was not regularly offered to Ben King and when the Sports Instructor was absent for lengthy periods of time, there was no replacement
7. Multi-Disciplinary Team (MDT) Meetings were not held every 4 to 6 weeks as required. At MDT meetings which did take place, out of date weight measurements were recorded and relied upon for Ben. His increasing weight gain was not discussed at these meetings and weight loss was not set as a desirable or essential goal
8. JCP used the Pandora software system, (company Directors for Pandora are the same as for JHL and JRCSL) which is still used at the residential homes owned by JHL and JRCSL. Concerns were raised at the inquest in respect of this software system in that not all policies and documents were available to staff on the iPads provided, some of the documents were unwieldy and difficult to read (eg Personal Healthcare Plan), the Dietician recommended use of paper records in respect of Food and Fluid intake as these would be more accessible to staff and encourage the documents to be completed or in the alternative providing for the records on iPads to be more easy to access and complete
9. The internal investigation carried out following Mr Ben King's death did not capture the concerns raised at inquest
10. Evidence was heard that no substantive changes have been made at the residential homes owned by JHL and JRCSL following the death of Ben King and the closure of JCP to deal with these concerns

#### NNUH

1. Guidance was sought by Emergency Department (ED) when Ben King attended on 10 July 2020 from a Respiratory Consultant, who was not made aware that Ben King had attended some 6 hours earlier with the same symptoms.
2. The Respiratory on call consultant was not contacted when Mr King returned to NNUH two days later on the 12 July 2020 with the same symptoms.
3. At the time of Ben King's attendance at NNUH, Ben King was under the Respiratory Team and had been seen a few days earlier, on the 3 July 2020. The Respiratory Team was not made aware of Ben King's attendances at ED on 9, 10 or 12 July 2020 with respiratory problems
4. Advice given on discharge appears to be unclear and contradictory. The expert Respiratory Consultant referred to the advice as being "*inadequate, unclear and inaccurate*"  
On the Discharge Form provided on 9 July 2020 it is noted "*Plan – home as Ben is back to normal, self, red flags and safety netting covered, to return in the event of any difficulty.*"

On discharge from ED on 10 July 2020 (second occasion) the hospital record states that Ben King is to return home, encouraged to lose weight, fluids are to be encouraged and *“with no need to monitor his sats unless clinically unwell with sats in 60s%”*. Not all of this information was included in the Discharge Form on 10 July 2020: The Discharge Form provided under *“Other” - “seen by respiratory team, they are happy to send him home, they have clerked their advice on the paper. Cpap and O2”*

On 12 July 2020 the Discharge Plan provided *“Home”*.

The advice from the Respiratory Consultant seen on 3 July 2020 was for CPAP to stop.

Evidence was heard from the Care staff at JCP that they were unclear as to what the plan was with regard to Ben and specifically as to when Ben was to be returned to Hospital. One of the Doctors at JCP contacted the ED, NNUH to try to ascertain what the advice was and was unable to get any substantive response. Email contact was made with the Respiratory Team but no response was received until after Ben King's death on 28 July 2020

5. The section headed *“Drug History”* was not completed on the Discharge Form on Ben King's attendances on 9 or 12 July 2020. On 10 July, it states *“nil significant”*. This is despite Ben King being prescribed Promethazine, a sedative medication, affecting the respiratory system. Evidence was heard that not all prescribed medications could be expected to be included in *“the small space”* provided. That this is a medication where consideration would have been given to a risk vs benefit analysis but there was no evidence of any such analysis. Regulation 28 evidence was that not all medication can be listed; only *“pertinent”* medication. Promethazine would appear to be such a medication
6. Arterial and venous blood gas samples were taken from Ben King on his attendances on 9 and 10 July 2020, which the Respiratory Consultant said in evidence were incomparable (although this was not the evidence of the Expert Respiratory Consultant). No blood gas samples were taken on the 12 July 2020

## 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 09 September 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], mother

[REDACTED], father

Dr [REDACTED]

Clinical Commissioning Group  
Norfolk Safeguarding Adults Review Group  
Care Quality Commission  
Department of Health  
HSIB  
Healthwatch - Norfolk

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 response 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.

**9. Dated:** 20 July 2021

A handwritten signature in black ink that reads "J Lake". The signature is written in a cursive style with a large, sweeping initial "J" and a stylized "Lake".

**Jacqueline LAKE**  
Senior Coroner for Norfolk  
Norfolk Coroner Service  
County Hall  
Martineau Lane  
Norwich NR1 2DH