	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Director of Adult Services Blackpool Council Bickerstaffe House 1 Bickerstaffe Square Talbot Road Blackpool FY1 3AH
1	**CORONER** I am Alan Anthony Wilson Senior Coroner for **Blackpool & Fylde**
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** The death of Kirandip Bharaj [known to her family as Kiran] on 14th September 2019 was reported to me and I opened an investigation, which concluded by way of an inquest on 30th September 2023. I determined that the medical cause of Kiran's death was: **1 a Fire fumes inhalation and burns** In box 3 of the Record of Inquest I recorded as follows: **Kiran Bharaj was aged 45 years. She had a history of mental health issues, having been diagnosed with transient psychotic episodes. She also had a known eating disorder, and had maintained a chronic low weight for some time. She was also known to be frail, with limited vision and hearing. In May 2019, it was felt there had been a deterioration in her mental health and a mental health assessment was performed but Kiran was not felt to be detainable and she remained in the community with support initially provided to her by a care company, and then with the aid of a support worker from adult social care. At shortly before 12.30pm on 14th September 2019, a neighbour became aware of a fire in Kiran's flat and alerted the fire service. When the emergency services entered her flat, they found Kiran deceased in the kitchen area. A subsequent fire investigation determined that the fire had been caused by the unintentional ignition of a cotton tea towel by turning on the wrong control on an electrical cooking ring hob. Once a fire had taken hold, and Kiran**

	has become aware of the fire, she approached the location and her clothing caught fire, and she suffered significant burns. She died quickly from the combined effects of the burns and from inhaling some fumes. In recent weeks, her weight had become more concerning and was being monitored by her GP. Kiran was referred to an eating disorder clinic on 23/07/19, but was not willing to give her consent to this. On 30/08/19, some 15 days before Kiran died, a support worker had raised a concern when Kiran appeared confused and had been unable to recognise her. In due course, she was the subject of a further metal health assessment on 6th September 2019. By that date, her weight was declining. The assessment was inadequate. There was a failure to sufficiently assess the status of her eating disorder at that time. Her presentation justified a period of detention in a hospital setting where her declining weight could have been stabilised, and the decision not to detain her was a missed opportunity. When social care professionals attended her home on 10th September 2019 and weighed Kiran, her weight had reduced further. A decision was taken to seek an inpatient eating disorder bed. Professionals could have convened an immediate mental health assessment, which may have led to admission to a general acute or medical bed rather than waiting for a specialist eating disorder bed to materialise. Discussions were held with a hospital on 12th September 2019, but there was no eating disorder unit bed free at that time. One would most likely have become available within the next seven days but not by the date of Kiran's death on 14th September 2019. There was some confusion amongst professionals about when a necessary mental health assessment would take place prior to Kiran being able to access the eating disorder bed, and who would be responsible for monitoring her in the community prior to hospital admission, but this did not contribute to her death. From the available evidence, it cannot be established that the circumstances surrounding the fatal house fire were more than minimally, trivially or negligibly contributed to by her mental disorder, nor by her eating disorder and how it was managed and responded to. In box 4 of the Record of Inquest I determined that Kiran died as a result of: **Accidental death**
4	**<u>CIRCUMSTANCES OF THE DEATH</u>** In addition to the contents of section 3 above, the following is of note: • Notwithstanding that I determined that it could not be established this fatal house fire was contributed to by Kiran's eating disorder and how it was managed and responded to, I was satisfied that I have a duty to write this report. • At the time of her death, Kiran lived alone her flat with support from adult social care. A support worker assisted her with tasks such as ordering prescriptions, booking taxis, medical appointments, for example.

- Although Kiran was said to have maintained a chronic low weight for some time, evidence before the inquest suggested that in the weeks prior to her death she lost significant weight, and could take steps to avoid accurate recording of her weight, such as on two occasions when she refused to remove her boots prior to being weighed. Her BMI was 14, and would reduce further. She was said to have been "presenting as not eating, and with an increased level of confusion" and no longer willing to have prescribed ensure drinks, something she had previously agreed to.

- The quality of assistance she received from professionals varied. A support worker was proactive in seeking to provide Kiran with the help she needed, By contrast, during an inadequate mental health assessment the extent of her eating disorder and a declining weight was not considered to the degree clearly required.

- This inquest was held some time after Kiran's death, the inquest having been necessarily adjourned on previous occasions for a range of reasons.

- The court heard how, at the time Kiran died, in terms of managing and treating an eating disorder the relevant guidance was what is often referred to as the **MARSIPAN guidance**. Some time later, from around May 2022, the Royal College of Psychiatrists replaced that guidance with their up-dated ***Guidance on Recognising and Managing Medical Emergencies in Eating Disorders,*** sometimes known as the **MEED guidance**.

- The court received evidence from a witness who at the time of Kiran's death had been Deputy Head of Adult Social Care and in her witness statement, she explained how it was part of her role to provide some level of oversight, and to identify any gap in services and address these. However, no significant internal investigation into Kiran's death had taken place since, and no changes have been made in response to her death.

- She confirmed that at the time of Kiran's death, Adult Social Care staff had not received training on how to recognise indicators of concern in relation to eating disorders.

- A support worker explained how what knowledge he had about eating disorders he had accumulated from his experience of dealing with service users allocated to him previously.

- Two approved mental health practitioners [AHMPs] employed by Blackpool Council confirmed this also applied to AMHPs, with training on eating disorders limited to whether they happened to choose an eating disorder module as part of their annual refresher training.

- There had been little if any awareness of the MARSIPAN guidance therefore around the time of Kiran's death.

	- In addition, adult social care witnesses were largely unaware of the more recent MEED guidance, and the court was told no steps had been taken to bring the new MEED guidance to the attention of staff, nor to provide specific training on eating disorders. - Although the court was told that workers in adult social care do have access to colleagues working in an eating disorder service with who they can discuss their service users, they are only likely to do so upon having recognised that there may be a potential problem relating to an eating disorder. Having considered all of the above, I have determined that I have a duty to write this report.
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 send the report: The **MATTER OF CONCERN** is as follows. – Eating disorders are increasingly prevalent. An eating disorder is a mental disorder and with a known high risk of mortality. Many vulnerable people live in the community with support from adult social care, but who may not have access to specialist eating disorder services, perhaps due to a lack of availability or because they are reluctant to engage with specialist services. As part of their illness, they may be reluctant to discuss their condition with family members, friends, or attend their GP surgery for monitoring of their weight. It is important that adult social care staff, should they become aware of concerning signs of a previously unknown eating disorder problem, or identify a possible deterioration in the condition of a service user previously diagnosed with an eating disorder, take action within their range of powers to raise such concerns with the appropriate professionals, and possibly family members. I have a concern that in the absence of the tools, training and access to the relevant guidance, well - meaning adult social care staff may not recognise when a situation arises and the service user will go without necessary and often very urgent, medical assessment and treatment, and with fatal consequences. I do not seek to be prescriptive about what should now happen, and that is not the purpose of this report. I simply raise the concern.
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, and so on or before **6th December 2023.** 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] [Kiran's Sister] • [REDACTED] [GP] St Paul's Medical Centre Dickson Road North Shore Blackpool 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, 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	09/10/2023 Signature___ [signature] ______________________ Alan Anthony Wilson Senior Coroner **Blackpool & Fylde**