REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. Chief Executive and Chair of Unity MAT (Concerns 1 and 2 only)
2. Health and Safety Executive (concern 3 only)

1 CORONER

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 INVESTIGATIONS and INQUESTS

Owen Paul Garnett died on 11 January 2023 at Warwick Hospital, Warwickshire. I had jurisdiction to hear an inquest into his death, which concluded on 27 October 2023. My conclusion was misadventure.

4 CIRCUMSTANCES OF THE DEATH

Owen was a 19-year-old student at the Welcome Hills school. Owen was regarded as having a severe learning difficulty.

Owen had numerous health problems including a difficulty in swallowing. He also suffered from Pica (an eating disorder characterised by a tendency to eat non-edible substances).

Because of this tendency, Owen needed to be constantly watched to ensure that he did not eat such items. This was recognised in the school's risk assessments which initially recorded that Owen should '*Never be left alone when out*' and to which was later added in bold '*NB due to Pica, a named person must watch Owen at all times, to ensure he doesn't eat anything particularly leaves and twigs*.'

However, his carer noted that Owen was consuming items whilst at school such as twigs and other non-edible items. She raised this issue with the school on many occasions over a number of years. She was monitoring his stools and had photographs of such items in his stools. She sent the photographs to the social worker and believed they had been forwarded to the school. The school say they did not receive the photographs, but they were certainly aware of her concerns. In November 2022, Owen's carer specifically raised concerns surrounding blue paper towels at a meeting attended by Owen's class teacher.

On 4 January 2023 Owen was discovered to have blue paper towel in his mouth and a message was sent to his carers saying this had occurred. A near miss report made but no action was taken as a result of the report.

On 9 January 2023, contrary to the requirements of his risk assessment, Owen was outside of the classroom and was unsupervised.

When Owen was located, it was discovered that he had crammed a significant amount of blue paper towel into his mouth and throat and was choking.

Resuscitation attempts were made, and Owen was transported to Warwick Hospital. Owen had suffered a hypoxic brain injury. A decision was taken to remove life support and he died on 11 January 2023.

CORONER'S CONCERNS

During the course of this 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.

It is noted that a recent Incident report has been produced by Unity MAT, together with an action plan.

The MATTERS OF CONCERN following the inquest into Owen's death were as follows:

1. The evidence showed that the concerns of Owen's carers were not acted on. Evidence was given that had the school seen the photographs they would have been more likely to have reacted to the information, but less weight was placed on an oral report by carers. The new plan seems to recognise that carers' concerns should be acted upon by recording as a near miss incident any health and safety concerns and these should be reviewed. It appears that the decision to regard any such concerns as relating to health and safety and then record the concerns can be made at class staff level. There is no guidance as to what should or should not be regarded as a health and safety concerns by staff. There is no guidance as to how carers will be assisted to participate in this process or what steps can be taken by carers who feel their concerns have been disregarded.

2. Had Owen been supervised as envisaged in his risk assessment, he would not have been able to consume the significant quantities of blue paper towel found in his mouth and throat. The class teachers' evidence was that after her initial training, the process of advice on prioritising of supervision was retrospective in that she only received feedback on events that had already occurred. The current plan appears to permit the class teacher to deviate from the planned supervision and prioritising of supervision in circumstances that are not made clear.

3. The Health and Safety Inspector present at the inquest indicated that the Inspectorate had not had the opportunity to review the plan and would be considering whether to participate further by reviewing the implementation of the plan. However, as the relevant inspector could not be present, it was unclear when the plan could be reviewed and by whom.

6 ACTION COULD BE TAKEN

In my opinion action could be taken to prevent future deaths and I believe that the addressees 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 2 January 2024. 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, Owen Garnett's family, the Chef Executive and the Chair of Unity MAT and the Health and Safety Executive

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 8 November 2023

Assistant Coroner Linda Lee