West London Coroner Service
25 Bagleys Lane, Fulham, London, SW6 2QA
[redacted]

Date: 2 January 2025
Case: [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Revon Healthcare

CORONER

1 I am **Lydia Brown Senior Coroner** for **West London**

CORONER'S LEGAL POWERS

2 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

INVESTIGATION and INQUEST

On 18 December 2023 I commenced an investigation into the death of James Stephen KEEN. The investigation concluded at the end of the inquest . The conclusion of the inquest was

3 Drug related death

1a Cardiotoxic Effects of Methamphetamine and Sildenafil

1b

1c

II

CIRCUMSTANCES OF THE DEATH

4 James was found deceased in his room at [redacted] Surbiton Surrey on 8 December 2023. He had a history of severe mental ill-health and substance abuse, together with diagnoses of autism and ADHD. He was living in supported accommodation and had input from community mental health services and seemed to be making progress with independent living, with a number of negative drug tests conducted prior to his death.

CORONER'S CONCERNS

5 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. -

[BRIEF SUMMARY OF MATTERS OF CONCERN]

(1) During the inquest the court was advised that the untrained support workers at the supported accommodation would conduct physical health checks including taking a temperature, oxygen saturation readings and pulse. The evidence was unclear as to whether blood pressure readings were taken. It was apparent that there was considerable confusion regarding what readings were being obtained, whether or not the readings were within normal limits, and what (if anything) the staff did with the results. The court was advised the thermometer at the home was broken.

(2) There seemed to be a real risk that the observations could give either falsely reassuring information and miss evolving ill-health indicators or be needlessly alarming for residents, by suggesting normal results were in fact abnormal, given the paucity of understanding of the support workers and lack of documentation.

(3) There was no evidence of induction or annual training or checking support workers understanding and ability to effectively carry out this quasi-nursing role, or that the qualified staff appreciated the lack of knowledge displayed in the evidence at inquest.

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

YOUR RESPONSE

7 You are under a duty to respond to this report within 56 days of the date of this report, namely by 28 February 2025. 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [NAMES] .

8 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.

2 January 2025

9 Signature 

Lydia Brown Senior Coroner for West London