Coroner Service
West Sussex, Brighton & Hove

Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Sussex Community NHS Foundation Trust** **2 Coastal Homecare - Hove Branch**
1	**CORONER** I am Karen TAYLOR, Assistant Coroner for the coroner area of West Sussex, Brighton and Hove
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 15 May 2025 I commenced an investigation into the death of John Malcolm FISHER aged 74. The investigation concluded at the end of the inquest on 11 March 2026. The conclusion of the inquest was that: John Malcolm Fisher died on 4 May 2025 at the Royal Sussex County Hospital in Brighton after being admitted on 22 April 2025 suffering from persistent focal seizures that over the next few days developed into status epilepticus, meaning the seizures were continuing without a break so there was no recovery period in between. Sadly, the seizures could not be controlled despite treatment and ultimately led to death due to a number of factors including an established history of epilepsy.
4	**CIRCUMSTANCES OF THE DEATH** Mr Fisher was admitted to the Royal Sussex County Hospital on 22 April 2025 suffering from regular focal seizures and although initially he did have some awareness, this declined over the next 24 to 48 hours. Questions were raised regarding recent antiepileptic medication compliance particularly missing doses of sodium valproate before admission as a new care agency had been administering his medicine and a query whether phenobarbital was being given or not. There were delays in inserting a nasogastric tube but Mr Fisher was managed with additional shorter acting benzodiazepines. In addition, the regular sodium valproate oral solution was reinstated and then increased. He was also given a sodium valproate infusion. Sadly, the decision was made on 28 April together with family agreement that Mr Fisher had reached the end of his life as his seizures could not be controlled and he died on 4 May 2025. The medical cause of death was given as 1a Status Epilepticus due to b) Epilepsy. Mr Fisher's first observed seizure was in November 2019 following surgery. A diagnosis of epilepsy was confirmed when several seizures were observed by medical staff in December 2020. Anti-epileptic drugs (AED) began including sodium valproate. Mr Fisher was admitted to hospital twice in quick succession in 2021. His second admission on 9 March 2021 was protracted and he was not discharged until 18 June 2021. However, the doctors could find no clear cause for his seizures despite extensive investigations as well as increasing the number and doses of antiepileptic medication and care in the intensive therapy unit. He was discharged from hospital on 4 different types of anti-

	epileptic medications including sodium valproate and phenobarbital. He remained seizure free for almost 4 years until his admission to Brighton hospital on 22 April 2025.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: Overall, after hearing evidence over two days regarding the administration of Mr Fisher's AED medication, I remain concerned that patients in the community are at risk of either being given medication that has been discontinued by a GP or not being given essential medication to control seizures. 1) I heard evidence from Mr Fisher's GP practice (Trinity Medical Centre) that they received a letter from Brighton Urgent Community Response (UCR) team indicating that they had, in turn, received a referral from the local Adult Social Care Team requesting a package of care assessment on 8 April. This assessment was carried out on 9 April and from handwritten medication administrative records (MAR) complied by the UCR Team from Brighton hospital, support was provided to Mr Fisher until 15 April. According to the UCR records this apparently included phenobarbital tablets twice a day even though Mr Fisher's GP had discontinued the phenobarbital on 8 April 2025. 3 liquid AEDs were also given including sodium valproate. 2) It is far from clear whether the UCR records are accurate regarding whether phenobarbital was given or not. The handwritten evidence says it was given but not whether this was from a blister pack or a separate box. Mr Fisher's community pharmacist gave evidence that for some years he had dispensed phenobarbital in a separate box and not in a blister pack. 3) UCR then arranged for a care agency, Coastal Homecare, to take over supporting Mr Fisher. During the inquest I saw a referral form prepared by UCR confirming that Coastal Homecare were required to assist Mr Fisher three times a day to help with his personal care and medicine administration. However, the only medication information that was supplied by the UCR team to Coastal Homecare referred to blister packs and liquid medication including antibiotics for chest infection. No further details of current regular medication, dosage, timing or form of medication (eg blister pack, separate boxes or liquids) were provided at all. In addition, the antibiotics were only for a short number of days but no clear indication is given when they were to stop and may well have finished by the time Coastal took over care. 4) Coastal Homecare confirmed that an assessment of needs was carried out on 15 April 2025 by a supervisor attending Mr Fisher's home address. The UCR handwritten medication forms were used to digitally record the required medications into the Coastal Homecare electronic system. Initially I was told that photographs of the medication were taken as well but on checking no photographs could be recovered save one of skin creams. It is apparently not standard practice for photographs to be taken during this kind of assessment but during the inquest it was agreed this would be good practice in future to achieve greater clarity for daily carers who frequently change. 5) Coastal Healthcare indicated that a mistake was made when documenting the medications in that although the UCR handwritten forms included sodium valproate oral solution, this was not added at all into the Coastal Homecare electronic MAR chart. As a result, Coastal Homecare accepted that between 16 April to 21 April (6 days) Mr Fisher did not receive any sodium valproate oral solution. This was one of three liquid antiepileptic drugs Mr Fisher should have received to help control possible seizures. This mistake was

	not spotted at all and there is no system in place to cross check what has previously been given when there is a handover between different care agencies nor was there any liaison with the community pharmcy who regularly dispensed Mr Fisher's medication. 6) Coastal Homecare management then self-reported the incident to the local Adult Safeguarding Team and also the Care Quality Commission but at the time of the inquest there has been no follow-up by either organisation to ascertain if there are any lessons to learn for the benefit of other vulnerable patients.
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 May 13, 2026. 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] **Trinity Medical Centre** I have also sent it to **Osbon Pharmacy (Trinity)** [redacted] **Lead Pharmacist, Brighton Hospital** **Medical Examiner Office, Brighton** **Brighton & Hove Adult Safeguarding Social Care** **Care Quality Commission** **NHS England & NHS Improvement (reg 28 reports)** who may find it useful or of interest. 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 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. They may send a copy of this report to any person who they believe 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	Dated: 19/03/2026

[redacted]

Karen TAYLOR
Assistant Coroner for
West Sussex, Brighton and Hove