REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	THIS REPORT IS BEING SENT TO: **1. Secretary of State for Health** **2. Chairman of Western Sussex Hospitals NHS Trust** **3. Chairman of Sussex Partnership NHS Trust**
1	**CORONER** I am Michael Burgess, assistant coroner, for the coroner area of West Sussex
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 29 April 2014 I held and concluded an inquest (and investigation) into the death of Janet BLACKMAN, aged 66, The formal conclusion was that Mrs Blackman, died on 29 May 2013, at St Richard's Hospital, Chichester, from Pulmonary Embolism due to Deep Calf Venous Thrombosis, and that her death was due to Natural Causes.
4	**CIRCUMSTANCES OF THE DEATH** In the course of early 2013, Mrs Blackman became unwell. In April 2013, she was found to be hypertensive. During May she became increasingly unwell and lethargic, seeing her GP and ultimately on the late evening of 20 May 2013, was admitted to the "Admitting Medical Unit" ("AMU") via the A&E department of St Richard's Hospital, Chichester. There she was clerked in and various investigations and tests were initiated. Immediately before and on admission she was very low in mood and displaying symptoms suggesting that she was suffering from depression or some form of mental illness. The tests undertaken quickly demonstrated that she was suffering from Hyperthyroidism and, in consequence low sodium (hyponatremia). A Deep Vein Thrombosis assessment was carried out as part of the admission process using the NICE pro forma and she was commenced also on low molecular weight heparin, given by injection, by way of prophylaxis. Treatment for the Hyperthyroidism was started in the hope that addressing the organic complaint might also resolve, at least in part, the mental health issues. Mrs Blackman was reluctant to eat and drink and after 2 days also refused medication including the heparin prophylaxis. She received a number of visits from psychiatrists and it was accepted that Mrs Blackman's organic condition should first be addressed before she was referred on to the Psychiatric Unit, run by the Sussex Partnership NHS Trust. In the course of the evening of 25 May, 2013, she was considered physically fit to be discharged under s.2 of the Mental Health Act 1983 from the AMU to the Orchard Ward of the Harold Kidd Unit (HKU). Although her medication went with her, the HKU was not equipped to provide (i.e., administer) the heparin prophylaxis injections. At about 8:20 on the morning of 26 May, 2013, she was found collapsed in the HKU, with an oxygen saturation of between 81-85% (it should have been 96-97%), and described as "hypoxic". She was rushed back to the AMU, via the A&E department of the St Richard's Hospital, Chichester. Her Oxygen saturation levels were quickly restored to about 94% (still low, but better) and further tests were commissioned. She was again clerked in afresh and as before a Deep Vein Thrombosis assessment was again carried out and she was again prescribed low molecular weight heparin, to be given by injection. Some 30 hours later, in the course of the early evening of 27 May, she was returned to the HKU, where as previously mentioned, the prophylaxis heparin injections could not be

	given. In the late morning of 29 May, whilst still a patient on the HKU, she was found unresponsive. Despite CPR and removal to the A&E department of St Richard's Hospital she died at 2:05 pm. Her death arose from a Pulmonary Embolus due to Deep Calf Venous Thrombosis (of both legs). Putting aside the refusal of Mrs Blackman to accept the prophylaxis injections, it was impossible for there to be any continuum of the prophylaxis if it could not be given to Mrs Blackman during her periods away from AMU, as a patient of the HKU. Further it was suggested by the expert that the provision and then cessation of the prophylaxis followed by the resumption (and then a further cessation) may have made a DVT more likely. It cannot be known for certain how long Mrs Blackman had been developing the DVTs that ultimately gave rise to her death and, save for the lower oxygen saturation levels, she was generally asymptomatic.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows. – (1) The HKU like other units dedicated to the delivery of essentially psychiatric care are not able to deliver at least some of the elements required of the patient for her physical health (2) It would seem that the logic of the DVT prophylactic policy as recommended by NICE is not applied to those patients coming into the psychiatric units – or if it were then Mrs Blackman would have been subject to the same clerking process on each of her admissions to the HKU and thereafter would have been able to receive the prophylaxis care that had been prescribed for her in the AMU. (3) By way of emphasis and duplication, that if anything, the NICE recommendations and policy for DVT avoidance is as relevant to patients being treated in psychiatric units as in any other units providing patient care. (4) It should be possible to develop a system enabling a seamless delivery of care covering both the physical and mental health treatment including DVT Prophylaxis to a patient in a single unit without the need to move patients physically from one unit to another, even if different aspects of care are delivered by different trusts.
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 **24 June 2014**. 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] - Mrs Blackman's daughter and her solicitors, Messrs Pennington Manches, of Godalming, Surrey. 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	**29 April 2014** SIGNED - ***Michael Burgess*** (Assistant Coroner – West Sussex) pp GBurbeck