	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief executive, Sussex Partnership NHS Foundation Trust**
1	**CORONER** **I am Karen HENDERSON, 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 18th November 2013 I commenced an investigation into the death of Maureen Leaver, 83 years of age. The investigation concluded at the end of the inquest on the 25th November 2013. The medical cause of death given was: **1a. Bronchopneumonia** **1b. Hypothermia** **1c. Risperidone toxicity and sepsis** **II. Dementia, Type 2 Diabetes Mellitus, polypharmacy, Stage 3 chronic kidney disease, congestive cardiac failure (likely secondary to hypertensive heart disease)** 2. My narrative conclusion was: **Mrs Leaver suffered distressing delusions and hallucinations on a background of cognitive decline, which required an emergency admission for her own protection on 24th July 2010.** **During admission she was not fully assessed, investigated or given a formal diagnosis by a senior responsible clinician. She was prescribed risperidone. The dose was increased for uncertain reasons from 2 to 2.5 mg per day on 15th September 2010. The prescribing and monitoring of risperidone did not adhere to national or published local guidelines.** **Signs and symptoms of risperidone toxicity first became apparent on the 24th September 2010 but were not recognised as such. A chest infection was thought to be 'brewing' at the same time. No physical measurements were taken until 26th September 2010.** **Mrs Leaver was transferred to St Richard's hospital for emergency treatment of profound hypothermia on 26th September 2010. She was placed on the Liverpool Care Pathway on the 28th September and died on 6th October 2010.** **The safeguards in place at the time were inadequate to prevent this unfortunate chain of events from occurring.**
4	**CIRCUMSTANCES OF THE DEATH** Mrs Leaver was admitted into the Harold Kidd Unit under Section 4 NHA on 24th July 2010 for assessment, investigation and management of her severe delusions and paranoid thoughts and co-existent dementia which made her incapable of living safely at home. She remained in the Harold Kidd Unit until an emergency transfer to St Richard's hospital, Chichester on the 26th September 2010 for the management of profound hypothermia. During her time in the Harold Kidd Unit, there were little formal investigation, diagnosis or management plan put in place with regard to her care. The underlying causes of her hypothermia were considered to be Risperidone, which was increased for uncertain reasons along

	with cold ambient temperatures on the ward and incipient chest sepsis. There was a delay in the recognition of the severity of her signs and symptoms. She did not improve after correction of her hypothermia at St Richards Hospital and was, within 24 hours of admission placed on the Liverpool Care Pathway. She died on 6th October 2010.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise for concern. In my opinion there is a risk that future death 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: 1. The lack of medical supervision of in-patients in Grove Ward, Harold Kidd Unit and the lack of effective systems to investigate, diagnose and manage acutely ill elderly patients suffering from complex psychosis and associated dementia 2. A lack of understanding of the legal duties imposed by the Mental Health Act 1983 and the Mental capacity Act 2005 when transferring patients who cannot consent to treatment from Section 4 MHA 1983 to being an informal patient.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation: Sussex Partnership NHS Foundation Trust
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 24th March 2014. I, the coroner, may extend this 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] Matron Grove Ward) and to the local safeguarding board. 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	**DATE: 27th January 2014** **SIGNED: Karen Henderson Assistant Coroner** pp