| | REGULATION 28 REPORT TO PREVENT FUTURE DEATHS |
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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. Dr Matthew Patrick, Chief Executive, South London and Maudsley Trust, Bethlem Royal Hospital, Monks Orchard Road, Beckenham BR3 3BX** |
| 1 | **CORONER**<br><br>I am Andrew Harris, senior coroner for the jurisdiction of London Inner South |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 19th October 2011, I opened an inquest into the death of Sadik Miah, case ref 2654-11, date of birth 17 May 1968, date of death 15th October 2011. The inquest was heard on 4th June 2014. The conclusion of the inquest was given by a narrative verdict below. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Mr Miah suffered from schizophrenia and did not have insight into his psychosis, for which he needed to and did take Olanzapine 15mg daily. He was detained under the MHA in Lambeth Hospital for his safety, to manage his psychogenic polydypsia. On 15th October 2011, he collapsed suddenly and appropriate resuscitation did not prevent his death. He had a sudden cardiac death, which is recognised as a characteristic of schizophrenia and on the balance of probabilities the antipsychotic medication was a contributory factor to death, which occurred at 16.46 on 15/10/11 in Lambeth Hospital |
| 5 | **CORONER'S CONCERNS**<br><br>During the inquest it was heard that antipsychotics, including Olanzapine, may cause arrhythmias and that a cardiologist's opinion may be needed from time to time. In this case the last ECG done available was done in 2010 and showed a prolonged QT interval of 440, prior to transfer. [redacted] said that he had an ECG in A&E but that this was not monitored by psychiatrists.<br><br>During the inquest evidence was heard that he developed hyponatraemia from excessive drinking but the aetiology was not clear, although he was thought to have psychogenic polydypsia. A referral was made to an endocrinologist for a routine out patient appointment, for which there would be a 6-12 week wait. One of the possibilities of the cause was that it was medication related and it was agreed that such a delay was not appropriate. The court heard that there was a facility for emergency treatment for a physical illness, but apparently no facility for a medical opinion that was not an emergency but should not wait several weeks.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) [redacted] said that consultant psychiatrists caring for in-patients with physical health problems did not have the benefit of a fellow consultant physician visiting, examining and advising on management, as would occur in a DGH. This did create a risk of other deaths occurring and should be a concern for the coroner.<br><br>(2). It was reported that the Trust had been developing a Physical Health Policy and building corporate relationships, but that there was no national guidance about how |

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| | organizations should address these matters. The court was not informed of the extent to which there was resolution of the areas of concern of the coroner. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>(1) The concerns are brought to the attention of SLAM, so that it may report on the actions already taken and if appropriate consider further developments in policy or corporate agreements.<br><br>(2) This matter is one in which the local commissioners, the Royal College of Psychiatrist and DH have an interest, and they are copied into this report, to facilitate consultation, should the Trust find this useful. |
| 7. | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 24 August 2014. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Person: [redacted] (aunt). I have also sent it to [redacted], consultant psychiatrist at SLAM, [redacted] Head of Patient Safety at SLAM, The Secretary of the Royal College of Psychiatrists and the Secretary of State for Health, who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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.<br><br>If you would like further information about the case, please contact my officer, Miss Marianne Mitulescu, on 020 7 525 1081, marianne.mitulescu@southwark.gov.uk. |
| 9 | **[DATE]** 26th June 2014 **[SIGNED BY CORONER]** [signature] |