REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **The Chief Executive of Partnerships in Care (PIC)** 2. [redacted] **Ashfield House Surgery, Annesley Woodhouse**
1	**CORONER** I am Dr Elizabeth Didcock, Assistant Coroner, for the coroner area of Nottinghamshire
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 the 29th October 2014, I commenced an investigation into the death of Jayne Jowett, aged 30 years. The investigation concluded at the end of the inquest on 27th March 2015. The conclusion of the inquest was a Narrative as follows: On the 15th September 2014 Ms Jayne Jowett became unwell. She had intermittent but continuing respiratory difficulties, with low oxygen saturations at times in the days prior to her death. She was not taken to hospital for assessment. She died of a pulmonary embolus on the 23rd September 2014.
4	**CIRCUMSTANCES OF THE DEATH** Ms Jowett was resident at Annesley House, a Partnerships in Care facility, providing low secure and locked rehabilitation mental health care for women. She was detained under section 47/49 of the Mental Health Act 1983. She had a learning disability and a personality disorder. She was on a range of psychotropic medication, and had asthma. She was smoker. From the 15th September 2014 she was unwell with intermittent symptoms of dizziness, breathlessness and episodes of collapse, needing oxygen. She was seen by the doctors and nurses at Annesley House, and by her GP. Her vital signs were monitored using the National Early Warning Score (NEWS) system. Guidelines as to how to respond to rising NEWS were not followed, and no hospital assessment was organised. There were missed opportunities by both Partnerships in Care and by the GP to recognise and respond to her clinical condition in the days prior to her death Following the Hearing I received an additional statement and documents from Partnerships in Care addressing issues that arose during evidence. These documents went some way to addressing concerns raised, however, in my view there remain outstanding concerns that allow for the continuation of circumstances creating a risk that other deaths will occur if such matters are not addressed.
5	**CORONER'S CONCERNS** 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. – 1. PIC Staff Training in National Early Warning Scores: Training in both interpretation of scores, and response to escalation in scores has not to date demonstrated improvement in assessment of a patients clinical

	condition. The impact of training on patient assessment requires ongoing audit and monitoring. 2. PIC staff at Annesley House have low levels of understanding of the significance of clinical signs such as cyanosis, pallor, breathlessness, and the significance of a patient needing oxygen treatment. There are no plans currently in place to address this 3. There remains no clear current service level agreement regarding how best for PIC to work with the local GP surgery to provide high quality joint care. There is no clear guidance that ensures all information regarding a patient's physical condition is communicated to a GP when seeing a patient.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe you 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 the 3rd July 2015. 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. For the avoidance of doubt, I will require a response from Partnerships in Care to 1) and 2) above, and from the GP and PIC to 3). However, respondents are at liberty and encouraged to respond to all of the issues raised. Respondents may consider it advantageous to consider some of these issues jointly as well as individually. Should respondents favour supplementing their individual responses to all the above issues with a joint response, such a collaborative approach would be greatly welcomed but there is of course no obligation to do so.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted] (sister and Next of Kin) 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	**1st May 2015** **Dr E A Didcock**