	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Dr Matthew Patrick, Chief Executive, South London and Maudsley Trust, Bethlem Royal Hospital, Monks Orchard Road, Beckenham BR3 3BX**
1	**CORONER** I am Dr Andrew Harris, Senior Coroner, London Inner South
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	**INQUEST** On 9th December 2011, I opened an inquest into the death of: **Michael George, who died on 7th December 2011, at 02.40 a.m. in King's College Hospital, Case Ref: 03102-2011.** It was concluded before a jury on 12th June 2015. The court found that the medical cause of death was 1a Multi-organ failure 1b Hyperosmolar hyperglycaemic state, in schizophrenic treated with Olanzapine.
4	**CIRCUMSTANCES OF THE DEATH** The narrative conclusion included these matters in the record: *a) The Maudsley Hospital failed to address the risk of Mr George developing diabetes from the long tern use of Olanzapine and did not check his urine or blood sugar prior to 06/12/11.* *b) At 09.30 on 06/12/11 Mr George complained of being weak, tired, having blurred vision and making frequent trips to the lavatory and asked to see a doctor. At a case review meeting held at 11.00 a.m. on 06/11/12 the results of a urine test, which showed the presence of blood and glucose, a physician was not consulted, leading to an inadequate care plan....* *c) At 18.30 when the laboratory .. phoned through the blood glucose results... the precise measurement of 53.7 mm/l was misunderstood by staff, who did not appreciate that [his] condition was life threatening. As a result.... decisions regarding ..... transfer to A&E had an insufficient level of urgency.* [NB: There was no entry of 53.7 in records] *d) From 18.30 once these glucose results were received, the Maudsley Hospital attempted to transfer Mr George to A&E. However the time delay between 18.30 and 21.20, when he eventually arrived at A&E had a significant impact on his chances of survival because it delayed the administration of sufficient levels of fluid to aid his rehydration.* *e) The referral information from the Maudsley did not contain critical information about Mr George's background and current condition to enable A&E to appreciate the urgency of his condition and the difficulty of managing a patient who was refusing treatment.* It should be added that it was reported that for a large part, but not all of his hospital admission, he had capacity and exercised it to refuse investigations and transfer.

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. Two previous PFD reports on the care of physical illness in mental health wards run by the Maudsley Hospital had been made by this court: One (2654-11) was sent in September 2014 concerning a death in October 2011. It reported the opinion of an expert that there needed to be domiciliary visits by consultant physicians, as would occur in a District General Hospital. Another (0883-13) following a death from diabetic ketoacidosis, reported the lack of mandatory and regular glucose testing whilst on anti-psychotic medication. This was sent in January 2015 reporting on a death in April 2013. The **MATTERS OF CONCERN** are as follows. – Expert evidence was heard that: (1) The management spokesperson on the Action Plan at the inquest was unaware that the Trust had received these two court Regulation 28 reports, suggesting that senior management attached insufficient importance to them and the issue of physical health care of mentally ill patients. (2) Although there was now systematic recording of urine and blood glucose of patients on antipsychotics on the wards, the audit conducted and presented in court showed a number of patients who had refused these tests, but not demonstrated whether in subsequent weeks testing was conducted or whether these same patients, like Mr George, never had their glucose measured, noting that urine measurement was non invasive, and had an appropriate care plan to address these risks. (3) The Trust response to 2654-11 in September 2014 was that a research bid was being mounted and discussions held with commissioners and Kings College Hospital (KCH). Progress on this was not provided to the court and there had apparently not been action to reduce risks of deaths by ensuring there were domiciliary visits from consultant physicians at KCH (which is across the road from the Maudsley) to mental health wards, as reported to the Trust in 2014. The need to implement such a service was again reiterated by a different expert in this inquest. It is inferred from the expert opinion that failure to do so would mean that patients in SLAM in-patient units would be more at risk than those mental health patients in a district general hospital. (4) Whilst there had been individual learning and changes in training and note keeping and recording, it was unclear whether, in the absence of consultant physician advice, that the serious untoward incident investigation conclusion on urgent transfer would be heeded. It advised that there should have been immediate action to call an ambulance to effect transfer, despite lack of consent, when the blood results were known.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the South London & Maudsley NHS Foundation Trust has 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 Wednesday September 2nd, 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. If you require any further information or assistance about the case, please contact the case officer, [REDACTED]
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following Interested Persons: [REDACTED] and [REDACTED] (sisters). I have also sent a copy to [REDACTED] and [REDACTED] (experts who gave opinions in the inquest), Southwark Clinical Commissioning Group, the Royal College of Psychiatrists, and the Secretary of State for Health. 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]** **[SIGNED BY CORONER]** 9th July 2015 [REDACTED] I apologize for the delay in sending this report, which relates to staff illness.