	H M Coroner, London Inner South **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS** **THIS REPORT IS BEING SENT TO:** **1. Mr Saleem Asaria, Chief Executive Officer, The Cambian Group, 4th Floor, Waterfront Building, Hammersmith, Embankment, Chancellors Road, London W6 9RU** **2. Mr Ron Kerr CBE, Chief Executive, Guy's & St Thomas NHS Foundation Trust, Westminster Bridge Road, London SE1 7EH**
1	**CORONER** I am 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 3rd April 2014, I opened an inquest into the death of: **Lee Mark Anthony Bates, who died on 24th February 2014, at 01.18 hours, in Cambian Churchill London Clinic, [redacted]** It was concluded before a jury on 19th August 2015. The jury found that the medical cause of death was: 1a Zopiclone and Benzodiazepine usage and obstructive sleep apnoea. II Severe obesity and concluded that the death was an accident.
4	**CIRCUMSTANCES OF THE DEATH** The jury found that: *"At 0.18..... Mr Bates died. The cessation of breath resulted in the CPAP machine stopping. His death was due to a potentially fatal overdose of Zopiclone being ingested in conjunction with benzodiazepines* [Note: some were prescribed; some acquired] whilst *under one to one eyesight observation. No evidence was heard to indicate that staff were sufficiently trained in the implementation of one to one eyesight observation policy. Contributory factors to his death were sleep apnoea and obesity."* Technical evidence was admitted confirming that the Continuous Positive Airways Pressure (CPAP) machine delivered a prescribed pressure of air for sleep apnoea and was not a method of providing oxygen or a life support machine, but there was an event between 01.11 and 01.18. An engineer's evidence was that the machine stopped at this time, but this did not necessarily indicate absence of life as it could be due to one of three reasons: a) it was manually switched off . There was no evidence this had occurred. The machine was managed by Mr Bates and not by the staff, but he was reported to have gone to bed with the mask on his face. b) the mask has been removed . The mask was witnessed to be on his face at 04.00 and 04.30 when the alarm was raised and CPR begun. c) there was a leak from mask e.g. from poor facial hygiene, beard or break in mask. The CPAP mask and venting were inspected and were in good condition, with no blockage. The strap was fine and they fitted together properly. [redacted] gave evidence that his small beard would be insufficient to cause the cessation of recording.

	It was reported to the court that hourly observation was noted at 02.00 and 03.00. A nurse gave evidence that she heard his breathing and saw his diaphragm going up and down between 03.00 and 04.00. She and a support worker turned the light on at 04.00 and saw that Mr Bates was moving indicating he was breathing. At 04.30 the support worker, observing from 14 feet away, instinctively felt something was wrong, noting he no longer heard the background noise of the CPAP machine. The Cambian Churchill reported that since the death there had been a reissue of the observation policy, raised awareness of what it required and staff training. [redacted] who heads the sleep apnoea clinic which Mr Bates attended in GSTT said that his overnight oximetry showed he had falls in oxygen levels of 100 per hour, which were reduced to 2.5 per hour with the use of CPAP. He had therefore very severe sleep apnoea, which was dramatically controlled by use of CPAP. [redacted] said that there is cumulative damage if the CPAP machine was not used. At night it would reduce, but not eliminate the risk of death. He said that Lorazepam theoretically has an effect on breathing. It should not be used in untreated sleep apnoea. If used when CPAP was on, it had the potential to make the sleep apnoea worse. The impact is statistically small, but in more severe sleep apnoea is more likely to have an effect. He was at a loss to predict if its prescription had contributed to death. He said that the consultant neurologist who saw him in the sleep clinic did not know he was to be prescribed Haloperidol or Lorazepam. He gave no warning or information about risks of prescribing. The professor said that Lorazepam should be avoided, but did not criticize its prescription, and would have expected the psychiatrists to contact the sleep clinic if they needed advice. If Mr Bates had to have sedative drugs, and was in his hospital, [redacted] said that he would be monitored with an oximeter.
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. – The court heard that neither the psychiatrists sought advice from the sleep apnoea clinic nor did the clinic inform the psychiatrists of the importance of using CPAP, the risks of not doing so and the risks of sedative medication especially if not using it and the desirability of oximetry. [redacted] director of the hospital, said that there was no guidance from GSTT about the use of the CPAP machine, of which psychiatric staff would not be familiar. He presumed that none of the psychiatrists sought guidance about medication, observation or use of the machine in a patient with severe sleep apnoea, as they did not see the need. He expected that the sleep clinic would provide any advice that psychiatrists needed in managing the OSA in a psychiatric unit. [redacted] consultant psychiatrist at Cambian, acknowledged that there were risks of death to people with severe OSA given drugs and then not taking CPAP. Physical health care needs were advised by GPs. He said that psychiatric staff did not know about the importance of CPAP, nor whether introduction of a drug required monitoring. There is the facility to use pulse oximetry in the hospital, but the implications, if it were to be used in all OSA patients, would need to be considered. There are many OSA patients in Cambian. It is clear that there is an on going risk of avoidable death in patients with OSA in Cambian Churchill hospital (especially if severe and associated with morbid obesity), Although this risk is reduced by use of CPAP machine and increased by use of sedative drugs, and may be mitigated by use of oximetry, such measures require dialogue between specialist physicians and psychiatrists and might require special provision for monitoring of patients that are high risk and require sedation. Neither hospital has addressed how this dialogue is to be instigated when required, nor how these risks should be addressed; reliance on GP advice seeming to be insufficient.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the 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 Thursday 12th November 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] (NOK), [redacted] Professor of Sleep Medicine Guy's & St Thomas' Hospital, [redacted] Consultant Psychiatrist at Cambian Churchill, I have also sent a copy to, [redacted] Chief Executive South London & Maudsley Trust, [redacted] Cambian Commissioner, [redacted] Chair of Joint Commissioning Panel for Mental Health Services, [redacted] Royal College of Psychiatrists and Rt. Hon Jeremy Hunt 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]** 17th September 2015 **[SIGNED BY CORONER]**