REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Dr P Miller, Chief Executive** **Leicestershire Partnership NHS Trust,** **Riverside House,** **Bridge Park Plaza,** **Bridge Park Road,** **Thurmaston,** **Leicester.** **LE4 8PQ**
1	**CORONER** I am Catherine Mason, senior coroner, for the coroner area of Leicester City and Leicestershire 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	**INVESTIGATION and INQUEST** On the 23rd April 2014 I commenced an investigation into the death of David Granville Oswald Hughes. Cause of death 1a Peritonitis 1b Perforated duodenal ulcer
4	**CIRCUMSTANCES OF THE DEATH** Mr. Hughes was a patient at the Bradgate Unit, Glenfield Hospital, Leicester. He had been admitted to the hospital on the 18th April 2014 after the police had found him wandering the halls of a hotel and had classed him as vulnerable. Whilst at the hospital Mr. Hughes refused to engage with staff and was placed on 15 minute observations that were to check that he was safe and well. These observations do not include physical observations such as blood pressure, pulse and respirations but they were to be conducted by properly checking Mr. Hughes and engaging with him at each prescribed interval. Mr. Hughes was to have physical observations taken as part of his admission but he continued to refuse to have this taken and medical evidence is that he had the capacity to make this decision. Mr. Hughes was found unresponsive lying on his bedroom floor collapsed at approximately 02:00 hours on the 23rd April 2014. It is clear from the evidence that there were serious failings in his care in so far as he was not observed in accordance with his medical needs. However, medical evidence is that there were no physical signs that Mr. Hughes was unwell such that action could have been taken to prevent his death. Therefore, while the recording of his observations fell way short of an acceptable standard, this failure did not cause or contribute to his death.
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. Level 2 observations were not conducted at the prescribed time intervals and periods of up to two hours lapsed between observations that should have been conducted every 15 minutes. When observations were conducted they were not always carried out as per the protocol. Assurances have been given at previous inquests that the performing and recording of these observations would be monitored, audited and staff would be trained regarding the importance of such observations. The same assurances were given at Mr. Hughes' inquest. It therefore appears that changes have not been made or if they have they are not working. Alternatively, changes may occur in the short-term but they are not being maintained and therefore the monitoring and auditing systems, if implemented, appear not to be working. 2. Fluid balance charts were not properly completed. There was no uniformity as to how or when staff would record fluid intake. Some staff would record fluid if they gave Mr. Hughes a drink. Some would record if they witnessed Mr. Hughes drink it. Therefore, the fluid balance charts were rendered meaningless. 3. Patient bedrooms are not fitted with a call bell system. The staff rely on patients being able to leave their bedroom and seek help or be able to shout loudly enough to be heard. Clearly, a patient who is so unwell that they can do neither would not be able to alert staff that assistance was required. 4. The nursing staff who gave evidence were Registered Mental Health Nurses or Health Care Support Workers. The evidence that they gave suggested they may not appreciate the signs and symptoms of a physical problem / illness. One nurse said that he would not. Although it is understood that discussions have taken place regarding the recruitment of 5 Registered General Nurses to supplement the 2 already in post at the Bradgate Unit and address this concern, it is understood that recruitment has not yet occurred and no date for commencement of recruitment could be given.
	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 5th April 2016. 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.
8	COPIES and PUBLICATION I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted] CQC Department of 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	**9th February 2016** **[SIGNED BY CORONER]**