REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** The Chief Executive of the 5 Borough Partnership NHS Foundation Trust, Hollins Park House, Hollins Lane, Winwick, Warrington, WA 2 8WA
1	**CORONER** I am Rachael Clare Griffin, Assistant Coroner, for the Coroner Area of Manchester West.
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 2nd February 2016 I commenced an investigation into the death of Clarice Beverley Hilton, born on the 29th October 1936. The investigation concluded at the end of the Inquest on the 20th May 2016. The Medical Cause of Death was:- 1a Bilateral Pulmonary Embolism 1b Deep Vein Thrombosis The conclusion of the inquest was that Clarice Beverley Hilton died as a consequence of naturally occurring disease where she was suffering from depression and anxiety and as a consequence she was less mobile, eating and drinking less which led to dehydration, refusing to take medication which included prescribed anticoagulation therapy, and refusing to allow medical staff to undertake physical observations upon her to determine whether she required transfer to the Medical Assessment Unit.
4	**CIRCUMSTANCES OF THE DEATH** On the 21st January 2016 the deceased, who suffered with depression and anxiety, and who was prescribed Rivaroxaban for Atrial Fibrillation, was admitted to the Cavendish Unit, The Avenue, Leigh Infirmary, Leigh under Section 2 of the Mental Health Act 1983 due to her refusing to eat, drink and take her prescribed medication. She was physically assessed on admission and her Modified Early Warning Score was zero. She continued to refuse to eat and take her medication and only drank minimal fluids. She also refused to allow

	the medical staff to undertake any observations to record her vital statistics after the evening of the 21st January. Her Modified Early Warning Score was not therefore further assessed. On the 23rd January 2016 there had been a deterioration in her physical health and she became unresponsive on the Unit. She was transferred to the Royal Albert Edward Infirmary, Wigan where she died that day.
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. During the inquest evidence was heard that:- i. The Cavendish Unit is a specialist psychiatric unit which provides assistance to patients with mental illness. The Unit does not provide medical treatment for physical illness. If a patient admitted to the Unit requires medical treatment, they will be transferred to the Medical Assessment Unit at the Royal Albert Edward Infirmary, Wigan which is part of the Wrightington, Wigan and Leigh NHS foundation Trust. ii. To assess a patient's physical health the nursing staff working on the Cavendish Unit undertake observations twice a day on each patient to ascertain if they require any medical treatment from a physical health point of view. These observations include measuring the patient's temperature, oxygen saturations, heart rate, blood pressure amongst other things. In carrying out these observations the nursing staff are able to calculate the patient's Modified Early Warning Score (MEWS). In a patient who has no physical health problems this score will be zero, however if the measurements recorded fall outside the normal parameters, this will increase the MEWS and may trigger a physical medical assessment by a Doctor to establish if medical treatment is required. The level of the MEWS determines the level of assessment that is required. iii. In the care that was provided to Mrs Hilton these observations were not undertaken as she refused to allow the nursing staff to assess her after the first evening of her admission on the 21st January. This resulted in her MEWS not being calculated for a period of over 24 hours prior to her death. During the course of the Inquest evidence was given that those working on the Cavendish Unit, and in fact all the other psychiatric units within the Trust, do not have access to guidance as to what action to take if a patient refuses to have their physical observations undertaken. It was felt that if there was such guidance this would be of benefit to the staff on the Unit to know what to do in such situations and when to seek an assessment by a Doctor. Evidence was given that such a policy could prevent the death of a patient in the future.

	2. I have concerns with regard to the following:- i. That there is no policy or guidance in place within the psychiatric units governed by 5 Boroughs Partnership NHS Foundation Trust as to what action to take when a patient is refusing to allow the nursing staff to undertake observations to establish the condition of their physical health. I therefore request that consideration be given to establishing a policy within the Trust for the monitoring of the physical health of patients within the psychiatric unit in circumstances where a patient refuses to allow the nursing staff to calculate their MEWS, which would provide guidance to the nursing staff as to what action should be taken in these circumstances and when it is appropriate for a referral to be made for a Doctor to assess whether a patient requires transfer to the Medical Assessment Unit for further assessment and treatment.
	ACTION SHOULD BE TAKEN In my opinion urgent action should be taken to prevent future deaths and I believe you and your organisation 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 28th July 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:- 1. [redacted] Mrs Hilton's husband. I have also sent this report to the Chief Executive of the Wrightington, Wigan and Leigh NHS Foundation Trust, Wigan Lane, Wigan, WN1 2NN and Wigan Borough Clinical Commissioning Group, Wigan Life Centre, College Avenue, Wigan, WN1 1NJ, who may find it useful or of interest. 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	**Dated** **2nd June 2016**
	Signed **Rachael C Griffin**