Regulation 28: Prevention of Future Deaths report

Doreen Elma STAPLETON (died 15.09.16)

	THIS REPORT IS BEING SENT TO: **1. Mr Simon Pleydell** **Chief Executive** **The Whittington Hospital NHS Trust** **Magdala Avenue** **London N19 5NF**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 29 September 2016, one of my assistant coroners, Richard Brittain, I commenced an investigation into the death of Doreen Elma Stapleton, aged 78 years. The investigation concluded at the end of the inquest on yesterday. I made a narrative determination at inquest, which I attach to this letter.
4	**CIRCUMSTANCES OF THE DEATH** Doreen Stapleton died on 15 September 2016 at the Whittington Hospital from a pulmonary thromboembolism.
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.

Doreen Stapleton had been admitted to the Whittington Hospital previously and diagnosed with pulmonary emboli. Upon discharge, ten days before her death, a plan was made for district nurses to attend her home daily, to administer tinzaparin injections. However, the referral was never received by the district nursing team, because an obsolete email address that had not been deleted from the computer system was used.

I am satisfied that Whittington Health has already taken steps to deal with the cause of the failure of the district nursing team to attend – the obsolete email address. I write in respect of an ancillary, but nevertheless important matter, that of the instructions given to Ms Stapleton and her family upon discharge.

During her six day admission, Ms Stapleton was told explicitly by one of her treating consultants that without medication she could die, and she did understand this. She was then persuaded to remain in hospital for treatment. However, she later decided that perhaps she wanted to leave after all, so on the afternoon of Friday, 2 September 2016, she was detained under section 5(2) of the Mental Health Act.

By Monday morning, she was deemed fit for removal of the section, and fit for discharge. It well may have been that her confusion on the Friday had been a consequence more of her low oxygen saturations at that time, than of her schizophrenia. Nevertheless, she was a vulnerable patient.

When she was discharged, although the plan of daily district nursing visits was made clear to her, no member of the team had another very explicit conversation with her or with her two sons, about the potential consequence (i.e. death) of the visits and medication administration not taking place. She and her sons were not given the telephone number of the district nursing team and were not told to ring if nurses failed to attend the following day. I understand that patients are now all given a leaflet with the district nursing team telephone number, but I am concerned that there is still a lack of emphasis on this aspect of discharge advice.

I heard from one witness that this is a whole team responsibility. Any member of the team – consultant physician, consultant psychiatrist, discharge nurse – could have had this very direct conversation with Ms Stapleton and her family, but nobody did. I appreciate that there may be a reluctance to be so blunt because of a fear of scaring patients, but any reluctance must be overcome in certain situations if patients are to be supported in the best way possible. Indeed, it had already been overcome by one consultant earlier in Ms Stapleton's admission.

6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 24 April 2017. 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 following. • HHJ Mark Lucraft QC, the Chief Coroner of England & Wales • Care Quality Commission for England • [redacted], sons of Doreen Stapleton 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 24.02.17