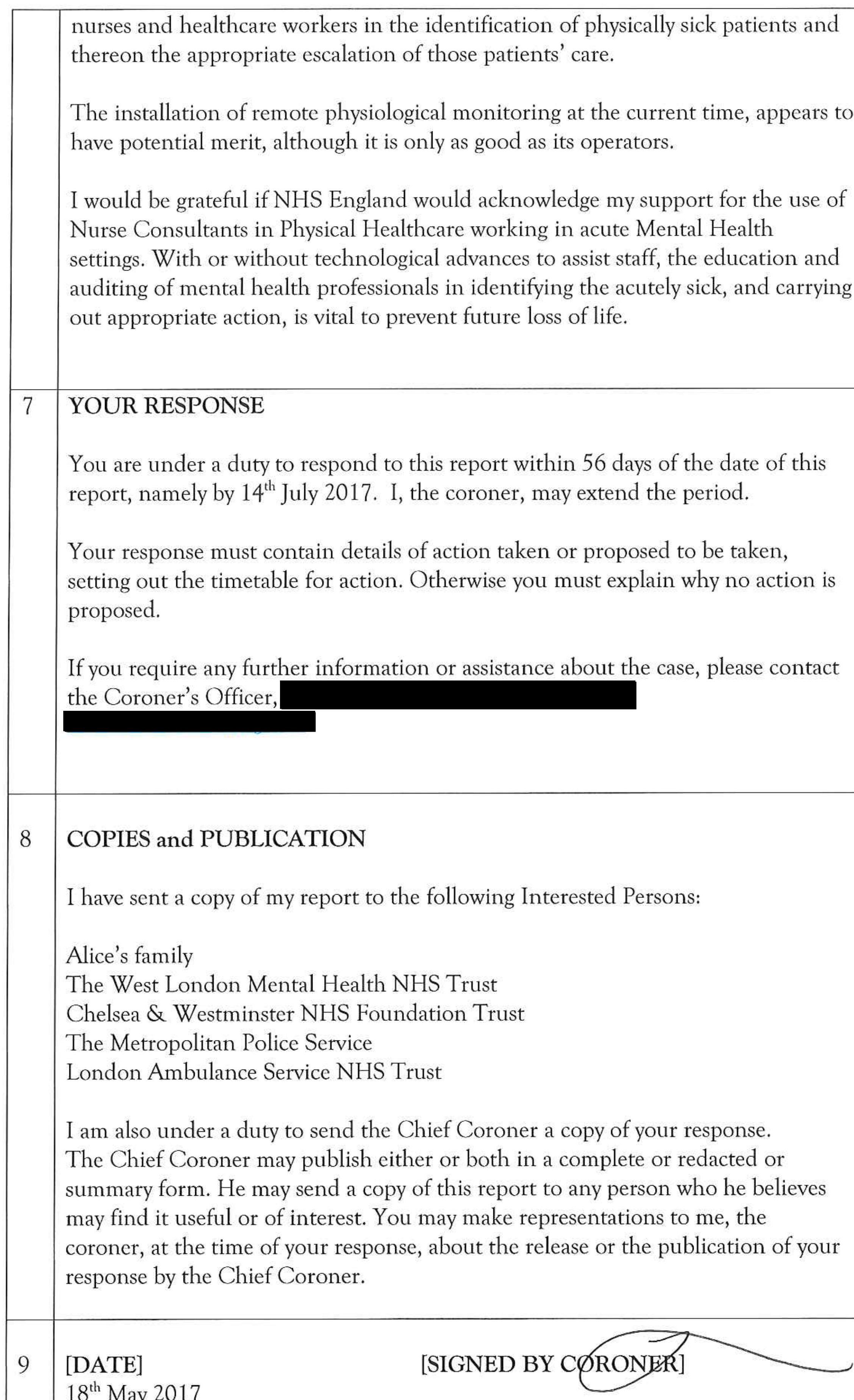
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Mr Simon Stevens Chief Executive, NHS England, Skipton House, 80 London Road, SE1 6LH
1	**CORONER** I am Sarah Ormond-Walshe, Assistant Coroner, West London jurisdiction
2	**CORONER'S LEGAL POWERS** I make this report 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 26th November 2012 the court opened an investigation into the death of: Alice Amaryllis Gibson-Watt ("Alice"). She had died on 20th November 2012. **The inquest was concluded on 27th April 2017.** A jury found: That the medical cause of death was: 1a Hypoxic ischaemic brain injury 1b Cardiac arrest 1c Trauma to the liver 2. Post-partum steatosis How, when and where: On 14th November 2012, Alice Gibson-Watt was admitted to Chelsea & Westminster Accident & Emergency with suspected post-partum psychosis. She was medically assessed in A & E and found to be in good physical health. She was subsequently moved to Grosvenor Ward at Lakeside on 14th November at 11.27 am and put into her own ward bedroom where post-partum psychosis was confirmed. Following deterioration of her mental state on 15th November, Alice was placed in seclusion and administered the anti-psychotic drug Haloperidol (5mg IM). Seclusion started at 15.00 hours on 15th November 2012 and ended at 22.25. During this period, Alice was monitored within eyesight. However, monitoring and recording of vital signs were

	inadequate and insufficient and not in accordance with the Lakeside policy on observation and monitoring. Oral and written communication was poor and insufficient. Prior to Alice's seclusion and the administration of Haloperidol, opportunities were missed for a thorough medical assessment and ECG. Considering the liver laceration, there was no evidence of trauma when Alice was admitted to Lakeside, but there was evidence that by 05.30 am on 16th November 2012 an injury to the liver had been sustained. It was probable that a liver injury was sustained whilst Alice was having a psychotic episode leading up to seclusion; her liver was more vulnerable due to post-partum steatosis. Considering the cardiac arrest, Alice was found not breathing some time after 03.00 on 16th November 2012. She was checked for pulse and respiration by two separate members of staff. Lakeside alarm was raised around 03.15. A third, more senior member of staff arrived, removed Alice from the bed, checked pulse, airway and CPR was commenced sometime after 03.25. At 03.31 West Middlesex crash team and London Ambulance Service were called. The crash team arrived at around 03.34. LAS arrived at 03.35 outside Lakeside. There was a delay in the ambulance service entering the building due to a locked door to the unit and no member of staff to let them in. The defibrillator was used at 03.40 – despite there being a defibrillator available in the room it was not used by Lakeside staff. The defibrillator that was used was the one provided by LAS. Return of spontaneous circulation began at 03.48. Alice was then fully intubated and ventilated and was taken to the ITU at West Middlesex Hospital. She was transferred to King's College Hospital at 17.40 hours on 16th November 2012 due to further complications to the liver. Alice did not regain consciousness and died on 20th November 2012 at King's College Hospital at 11.39 hours. The Conclusion of the Jury was: Hypoxic brain injury, caused by cardiac arrest, to which neglect and gross failure of Lakeside staff to commence CPR and use a defibrillator contributed.
4	**CIRCUMSTANCES OF THE DEATH** Alice Gibson-Watt was a well 34 year old lady who had given birth to her first child a few weeks before she began to behave abnormally. She was behaving so psychotically on the evening of 13th November 2012 that her husband called for an ambulance. Alice was restrained by the ambulance staff, and then police, when she was taken to hospital. She was first a voluntary patient in a psychiatric assessment ward, Grosvenor ward at the Lakeside Mental Health Unit within the grounds of West Middlesex University Hospital and run by the West London Mental Health NHS Trust). Her diagnosis was post partum psychosis. Her behaviour became particularly chaotic and abnormal again on 15th November 2012 with Alice being aggressive. She was taken into seclusion and given 5mg Haloperidol intra-muscularly, and sectioned under s5(2) Mental Health Act 1983. She was thereon particularly sleepy and tried to sit on the floor when being escorted back to her room over seven hours later. Approximately 12 hours after having been given the Haloperidol she went into cardiac arrest. She had been sleeping continually. At the time of the arrest she was being observed, on "eyesight" 1:1 observations by a nurse. The jury heard that there was some delay in recognising her cardiac arrest and starting effective CPR. She died of hypoxic brain damage later at King's College Hospital on 20th November 2012.

	At the time that Alice was being observed, the Rapid Tranquillisation policy of the Mental Health Trust was not followed. The Rapid Tranquillisation policy directed that vital signs should be done every 30 mins until the patient is ambulatory and to include blood pressure, pulse and temperature. No ECG had been done, at a time when it was possible to do so, prior to the administration of Haloperidol. This is normally required to rule out an abnormal heart trace (prolonged QTc). A MEWS (modified early warning score) score of 1 was not acted upon. With or without the liver laceration at the time of cardiac arrest, Alice was presenting physically abnormally. The one set of observations taken temporally near to the cardiac arrest showed a pulse *prima facie* high (95 bpm) for a patient who was resting and Alice was very sleepy indeed and had been for a long time. Staff did not see cardiac arrests often in mental health settings and it was only the third member of staff examining Alice who properly identified CPR should start. When it did start, a defibrillator was not used immediately.
5	CORONER'S CONCERNS During the course of the inquest, the evidence revealed a matter giving rise to concern that in my opinion means that there is still a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTER OF CONCERN** is as follows. - The sad facts leading up to the death of Alice have not been the first set of facts where I have heard about the death of a young mentally unwell patient being cared for on an acute mental health ward and who becomes acutely physically unwell, goes into cardiac arrest and where attempts at cardiac pulmonary resuscitation prove unsuccessful. <u>Post-partum psychosis</u> 1 in 1,000 new mothers suffer from the dreadfully disabling and distressing disorder of postpartum psychosis. I have carefully considered whether to focus in on the care of patients with post-partum psychosis in relation to any PFD report. This is because I do <u>not</u> consider 1 in 1,000 is a low figure. This is a disorder associated with young women and a disorder with a good prognosis and one would hope the mortality rate is low. The disorder is an acute psychiatric emergency and carries with it symptoms that can clearly be as severe as one can conceivably imagine. However, the facts surrounding Alice's death raise issues involving arguably wider matters than the concentrating on the particular disorder itself. I have sufficient concern about a wider issue which warrants the writing of this

	Prevent Future Death Report (CJA 2009, Schedule 5, Paragraph 7; Regulation 28 Coroners (Investigations) Regulations 2013) to be sent more centrally. This is: The identification of acutely physically unwell patients being nursed in an acute mental health setting, and thereon appropriate escalation of care. In Alice's case, even before there were signs that she was physically unwell, there was no regular monitoring and documentation of physical vital signs to assist in identifying any trend/pattern in physical health. No serial measurements of her observations meant that abnormalities could not be easily, or at all, identified once they occurred. In mental health units the *threshold* that prompts the use of regular vital sign observations appears to be high, and there maybe good reasons for that and clearly this is a patient-specific issue. However, identification of patients who are becoming acutely physically unwell does need more attention in general, with or without reconsidering how readily vital sign observations are ordered. Even when the NEWS (previously MEWS) system is in place - a process which is there to assist in the identification of patients who are becoming acutely unwell - it is not always followed. This is a recurring theme I see as a coroner. Having policies and procedures in place does not appear to be sufficient. I am aware that **Nurse Consultants in Physical Healthcare** are now working in acute mental health settings. That seems like a big step in the right direction. I am told there are very few Nurse Consultants in Physical Healthcare working in mental health settings currently (maybe as few as six). I was impressed with the Nurse Consultant who currently works for the West London Mental Health NHS Trust. I am aware that remote physiological monitoring of patients in acute mental health settings has been trialled and this may assist in the future. As with the NEWS scoring system, predisposes that staff will accurately use, interpret and act upon abnormal observations appropriately. From what I have seen with the use of MEWS/NEWS scoring, this will be the challenge. Nurse Consultants in Physical Healthcare would be able to assist.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths. The employment of Nurse Consultants in Physical Healthcare in acute mental health settings will assist in respect of training mental health practitioners such as



nurses and healthcare workers in the identification of physically sick patients and thereon the appropriate escalation of those patients' care.

The installation of remote physiological monitoring at the current time, appears to have potential merit, although it is only as good as its operators.

I would be grateful if NHS England would acknowledge my support for the use of Nurse Consultants in Physical Healthcare working in acute Mental Health settings. With or without technological advances to assist staff, the education and auditing of mental health professionals in identifying the acutely sick, and carrying out appropriate action, is vital to prevent future loss of life.

7 **YOUR RESPONSE**

You are under a duty to respond to this report within 56 days of the date of this report, namely by 14th July 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.

If you require any further information or assistance about the case, please contact the Coroner's Officer, [redacted]
[redacted]

8 **COPIES and PUBLICATION**

I have sent a copy of my report to the following Interested Persons:

Alice's family
The West London Mental Health NHS Trust
Chelsea & Westminster NHS Foundation Trust
The Metropolitan Police Service
London Ambulance Service NHS Trust

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]
18th May 2017

[SIGNED BY CORONER]