ANNEX A

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. [redacted] **Medical Director of the Mid Yorkshire NHS Trust, Pinderfields Hospital, Aberford Road, Wakefield, WF1 4DG** 2. [redacted] **Medical Director of the South West Yorkshire Partnership NHS Foundation Trust, Fieldhead, Ouchthorpe Lane, Wakefield, WF1 3SP**
1	**CORONER** I am David Hinchliff, Senior Coroner, for the West Yorkshire (Eastern).
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 12th September 2016 I commenced an Investigation into the death of Margaret Elizabeth Conway, aged 68. The Investigation concluded at the end of the Inquest on 24th March 2017. The conclusion of the Inquest was Natural Causes, the cause of death being:- 1(a) Acute Myocardial Infarction 2 Acute Severe Colitis I also recorded that "Margaret Elizabeth Conway suffered with mental health issues mainly agitation and obsessive compulsive disorder. She had been admitted to Fieldhead Hospital where she became unwell with gastrointestinal problems ultimately diagnosed as colitis. Her care was transferred to Pinderfields Hospital, Wakefield, where her death was confirmed at 0110 hours on 3rd September 2016.
4	**CIRCUMSTANCES OF THE DEATH** Margaret Elizabeth Conway was a widowed lady aged 68 and was a retired Hospital Clerk who was the subject of Section 3 of the Mental Health Act. Mrs Conway was admitted to Pinderfields Hospital, Wakefield from Fieldhead Hospital, Wakefield, a psychiatric hospital, on 24th August 2016 with a one week history of diarrhoea and acute kidney injury. A CT scan showed that she had pancolitis. She had a sigmoidoscopy which showed an acute colitis but the cultures for which were all negative. She was given intravenous steroids on Friday 2nd September 2016. Mrs Conway suffered a cardiac arrest requiring multiple cycles of CPR. Despite all efforts her death was confirmed at 0110 hours on 3rd September 2016.
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. – With the assistance of Professor Stephen Curran, Consultant in Old Age Psychiatry and Clinical Lead who is based at Fieldhead Hospital and who was involved in Mrs Conway's care, I wish to address the issue of patients experience in mental health issues and who are in-patients at Fieldhead Hospital but who have or developed physical health problems acutely which require treatment. (1) The Acute Medical Wards Mental Health Services are geographically and operationally separate. (2) Transfers of patients who are experiencing both serious mental and physical health problems can sometimes be very challenging. (3) PLT Services are now more actively involved in patients transferring to the Acute Wards. (4) Closer working such as joint ward rounds and NDT working should be explored as well as the development of a clear pathway/flowchart to facilitate closer working and in the longer-term the development and use of a shared resource with a small number of jointly funded and managed beds. Such measures would improve the care of patients with both severe physical and mental illness and also reduce the need for multiple transfers between the two organisations.
6	**ACTION SHOULD BE TAKEN** In my opinion 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 June 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 Chief Coroner. 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	**Wednesday 3rd May 2017** **Signed:**