REGULATION 28: REPORT TO PREVENT FUTURE DEATHS.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • Sir David Dalton, Chief Executive The Pennine Acute Hospitals NHS Trust Trust Headquarters North Manchester General Hospital Delaunays Road Crumpsall, Manchester M8 5RB • Neil Thwaite, Chief Executive Greater Manchester Mental Health NHS Foundation Trust Trust Headquarters Bury New Road Prestwich, Manchester M25 3BL
1	**CORONER** I am **Anthony Mazzag H.M. Assistant Coroner** for the area of Manchester City.
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 18th July 2016, an investigation was commenced into the death of Ann Corfield who died at the North Manchester General Hospital on 3rd July 2017. She was 71 years of age. The Inquest, sitting with a Jury concluded on 7th February 2019. The Jury found the following as the medical cause of death:- 1. (a) Massive pulmonary thromboembolism; due to (b) Deep Vein Thrombosis in the Leg; due to (c) Dehydration, secondary to depression with catatonia. The conclusion of the Jury was:- Narrative: The deceased died as a result of not being given regular doses of enoxaparin and the failure to assess capacity contributed to by neglect.

4	**CIRCUMSTANCES OF THE DEATH** Mrs Corfield was 71 years of age when she died. She lived with her partner, [redacted]. She had two children from her previous marriage; a daughter [redacted] and a son, [redacted]. On 29th May 2016, Mrs Corfield was admitted to the Royal Oldham Hospital (ROH). She had a urinary tract infection and [redacted] was also concerned about a marked change in her behaviour. She had withdrawn socially over the preceding months and was depressed in mood. When she attended hospital, it was discovered that she had very low sodium levels. She was treated for this and made slow but good progress. By about 13th June, her sodium level had been corrected. Despite the improvement in her sodium levels, her mental health deteriorated significantly. She was eating very little, if anything, and oral fluid intake was very low. On admission to ROH, Mrs Corfield was assessed at high risk of developing a thromboembolism and was prescribed an anticoagulant drug, Enoxaparin. However, she refused Enoxaparin on a large number of occasions during her time at ROH. On 28th June 2016, Mrs Corfield was detained in hospital under section 2 of the Mental Health Act 1984 as a result of her deteriorating mental health. She was transferred to a mental health unit called Park House run by Manchester Mental Health Trust for possible treatment of her psychiatric condition. At Park House, Mrs Corfield was diagnosed with a severe psychotic depression. Essential treatment in the form of electro-convulsive therapy (ECT) was planned by [redacted], Consultant Psychiatrist. Unfortunately, Mrs Corfield continued to take very little oral fluids and she became dehydrated. Her condition deteriorated to such an extent that it was no longer safe to administer ECT. Intravenous fluids could not be administered at Park House due to the fact there were no suitably qualified nurses. Further, Mrs Corfield did not receive prophylactic anticoagulation in Park House. Although a prescription for Clexane was drawn up on 30th June, it was never administered. Due to her physical deterioration, Mrs Corfield was transferred to North Manchester General Hospital (NMGH) on 30th June, where, after spending several hours waiting in the Accident and Emergency Department to be seen by a doctor, she underwent intravenous fluid resuscitation. She then stabilised very quickly from a physiological point of view. However, late on 6th July, she suffered a cardiac arrest and died in the early hours of 7th July.
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:

Re: Pennine Acute NHS Trust

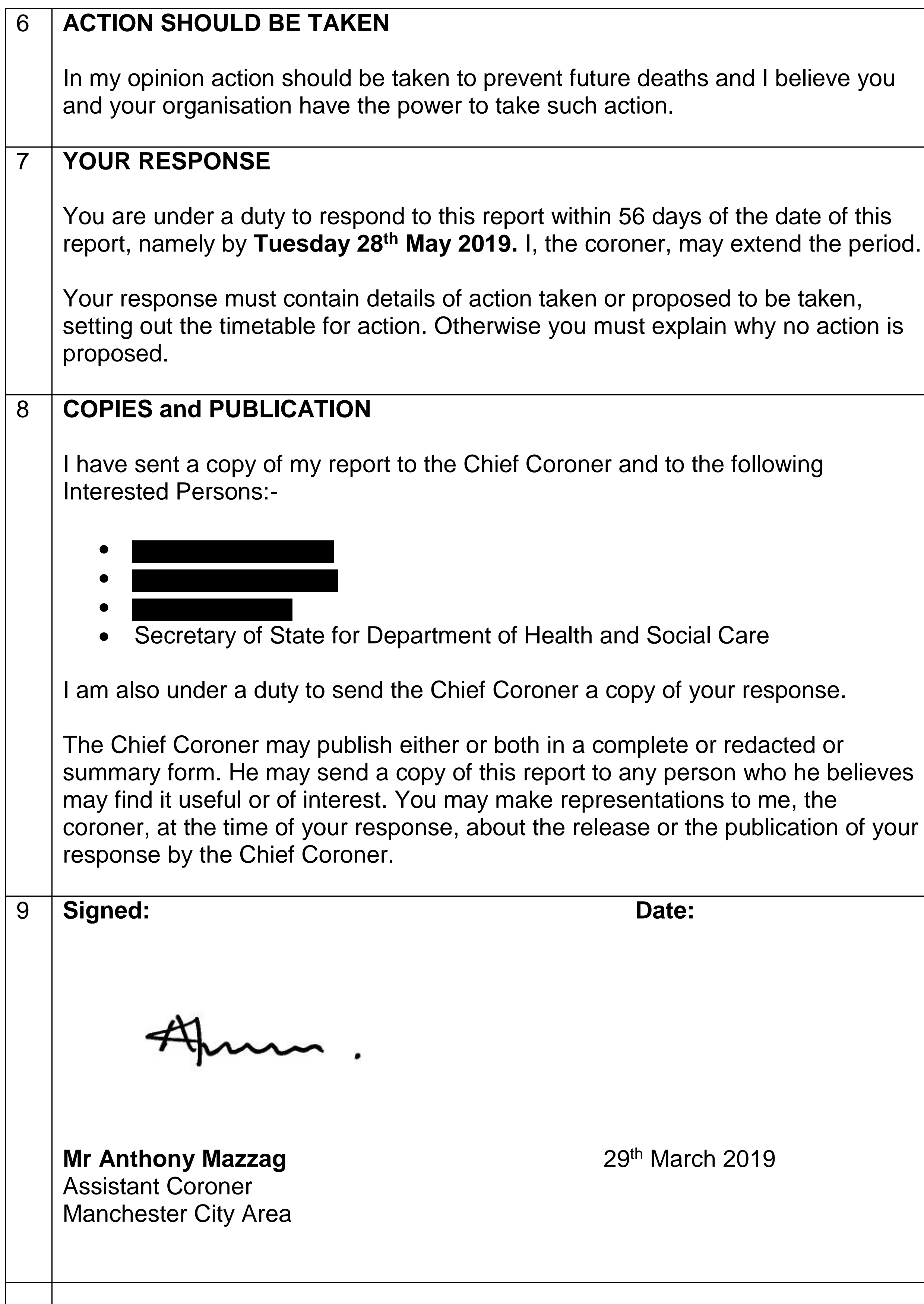
1. I heard evidence at the Inquest staff at Park House were not aware that Mrs Corfield was receiving an anticoagulant in the form of enoxaparin whilst she was a patient at Royal Oldham Hospital to reduce the risk of her developing a VTE or that she had refused this medication whilst a patient ROH. I received written evidence from [redacted] that the Pennine Acute Trust has in place an Adult Transfer Policy and a Form should be generated which includes details with regards the patient's medication and most recent observations. However, the evidence I heard from [redacted], Consultant Psychiatrist at Park House, was that his unit still does not receive a written handover.

2. Dehydration clearly played a part in Mrs Corfield's death. I heard evidence at Inquest that Fluid Balance Charts were poorly completed indeed some of them were not completed at all or contained errors with simple arithmetic. At the Inquest, I heard conflicting evidence about the usefulness of fluid balance charts. Witnesses who were employed by Pennine Acute Trust tended to place more reliance on the results of blood tests. However, [redacted] emphasised to me the importance of FBC charts in a patient like Mrs Corfield who had a history of chronic kidney disease because blood tests were an 'insensitive measure' of hydration. I received helpful written evidence from [redacted] who is the Divisional Director of Nursing for Medicine at Royal Oldham Hospital, dated 31st January 2019, which, at paragraph 17, shows there are still ongoing problems with the way fluid balance charts are completed some two and a half years after Mrs Corfield's death.

Re: Manchester Mental Health Trust

1. I heard evidence that although Mrs Corfield was at high risk of developing a VTE, following her admission to Park House on 28th June, prophylactic anticoagulation was not prescribed for her until 30th June when a prescription for clexane (enoxaparin) was issued. Further, although clexane was prescribed, it was never administered to Mrs Corfield.

2. Further, I also heard evidence that the staff at Park House were not trained to administer intravenous fluids. This meant that Mrs Corfield had to be transferred to a North Manchester Hospital for intravenous fluids when she was in urgent need of specialist psychiatric care and treatment. I formed the view that [redacted] was left extremely frustrated that he was unable to treat Mrs Corfield with intravenous fluids whilst she was a patient at Park House.



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 **Tuesday 28th May 2019.** 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] • [redacted] • [redacted] • Secretary of State for Department of Health and Social Care 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	**Signed:** **Date:** **Mr Anthony Mazzag** 29th March 2019 Assistant Coroner Manchester City Area