Regulation 28: REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 **West Norfolk Clinical Commissioning Group**
King's Court
Chapel Street
King's Lynn
Norfolk
PE30 1EL

2 **The Chief Executive**
Norfolk and Suffolk NHS Foundation Trust
Drayton High Road
Hellesdon
Norwich
NR6 5BE

3 **The Chief Executive**
Queen Elizabeth Hospital
Gayton Road
King's Lynn
Norfolk
PE30 4ET

4 **The Chief Executive**
Norfolk County Council
County Hall
Martineau Lane
Norwich
NR1 2DH

1 CORONER

I am Jacqueline LAKE, Senior Coroner for the area of Norfolk

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 30/11/2017 I commenced an investigation into the death of Tyla Katherine Joan COOK aged 16. The investigation concluded at the end of the inquest on 16/09/2019. The medical cause of death was:
1a Systemic inflammatory response of unknown cause
1b
1c
II Paracetamol Overdose

The conclusion of the inquest was: Natural causes contributed to by paracetamol overdose

4 CIRCUMSTANCES OF THE DEATH

Tyla Cook had a complex mental health history, including autism, and was under care of NSFT in the community. There was no up to date written Care or Crisis Plan in place. Due to his becoming less engaged and more distressed he was seen on 7 November 2017 and 8 November 2017. On 9 November 2017 at approximately 12.45 Tyla said he had taken 24 paracetamol tablets and refused to go to hospital. It was recognised there was an 8 hour treatment window within which an antidote was to be given to best effect. An ambulance arrived at 13:50. Tyla was discussed, assessed and deemed not to have mental capacity and was carried to the ambulance which left at 15:03. He became increasingly distressed during the journey. On arrival at the Queen Elizabeth Hospital at 15:14 there was discussion as to the best way to get Tyla into the hospital. He was given a sedative which had little if any effect. In the event, Tyla was removed into the hospital. He was then sedated and an antidote delivered at 18:00. Tyla received treatment and his condition was monitored. On showing signs of an infection he was treated with antibiotics. Against expectation Tyla's condition deteriorated and on 15 November 2017 at Queen Elizabeth Hosptial Tyla suffered a cardiac arrest and died.

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:

Norfolk and Suffolk NHS Foundation Trust

1. It was agreed at the CETR meeting on 9 August 2017 that Tyla was to be seen by the Eating Disorder Service. He was not seen until 25 October 2017. The evidence was the 11 week delay in seeing Tyla was due to a heavy caseload and the practitioner having to remove other cases from his caseload before he was able to work with Tyla;

2. There was no written up-to-date care and crisis plans in place. The most recent written care plan related to Tyla being an inpatient at the Dragonfly Unit, from where he was discharged on 9 August 2017. The written plans were therefore several months out of date. This is against Trust Policy. Evidence was heard that at a CETR meeting on 6 November 2017 a period of a further 3 months was requested to prepare an up to date written care plan. In the event, and despite the family's repeated requests for plans in writing, it was decided the care plan could be commenced by 30 November 2017, on the basis Tyla's input into the Care Plan was important and it would take time to gain his meaningful input. The evidence was that there were oral plans in place which were relayed to the parents (including at times of distress), who continued to request plans in writing. The high level of distress and anxiety within Tyla's home was recognised. An interim written plan was not considered nor that a written plan may have helped the family in providing support to Tyla. Steps have been taken by the Trust to recognise when up to date written plans are not in place and it is understood staff have undergone some work in improving the quality of care plans. However in this case an active decision was made not to update the written plan for some time. Further the evidence did not reveal any insight into the support a written plan could have given the family to support Tyla.

West Norfolk Clinical Commissioning Group, Norfolk and Suffolk NHS Foundation Trust, Queen Elizabeth Hospital and Norfolk County Council

3. The Review carried out by the West Norfolk Clinical Commissioning Group in May 2019 recommended a multi-disciplinary learning event involving participants from Norfolk and Suffolk Foundation Trust, Queen Elizabeth Hospital, Norfolk County Council and East of England Ambulance Service Trust be developed and implemented to train staff on how to apply good non-technical skills (teamwork, leadership, task prioritisation and communication) when responding to an emergency. At the inquest it became clear no steps have been taken to organise this event and

there is confusion as to who is responsible for arranging this learning event. The Care providers indicated it was for the West Norfolk Clinical Commissioning Group. The West Norfolk Clinical Commissioning Group do not appear to accept responsibility for organisation of the event. Tyla died on 15 November 2017. The West Norfolk Clinical Commissioning Group Review was published 8 May 2019. No steps have been taken with regard to this learning event, save East of England Ambulance Service Trust who has been in contact with the West Norfolk Clinical Commissioning Group. There is concern that a multi-disciplinary learning event will not be organised and will not take place.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe your organisations 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 12 November 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]
East of England Ambulance Service Trust
Norfolk Local Safeguarding Board (where the deceased was 18)

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: 17/09/2019

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Jacqueline LAKE
Senior Coroner for Norfolk
Norfolk Coroner Service
Carrow House
301 King Street
Norwich NR1 2TN