REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Department of Health and Social Care** **2. Chief Executive, Black Country Partnership NHS Foundation Trust** **3. Care Quality Commission (for information only).**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 the 12 August 2019, I commenced an investigation into the death of Ms Lisa Grant. The investigation concluded at the end of the inquest on the 15 December 2020. The conclusion of the inquest was a short form conclusion of natural causes. The cause of death was: 1a Bilateral Pulmonary Embolism 1b Deep Vein Thrombosis
4	**CIRCUMSTANCES OF THE DEATH** i) Ms Grant was admitted to Hallam Street Hospital on the 29 July 2019 under s3 MHA. She had been diagnosed with Bipolar Affective Disorder and had numerous previous admissions. ii) In terms of her medical history she had insulin dependent diabetes, iron deficiency anaemia, sickle cell trait and Raynaud's disease. Her medication included risperidone which is an antipsychotic or neuroleptic. iii) Ms Grant had gained weight and was obese. One of the common side effects of risperidone medication included eating more and therefore weight gain. Another rare risk factor is the risk of developing venous thromboembolism (VTE). iv) On the 1 August 2019 she collapsed on the ward and became unresponsive. Despite resuscitation attempts by staff and paramedics she sadly died a short time later at Sandwell Hospital.
5	**<u>CORONER'S CONCERNS</u>** 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. – 1. Evidence emerged during the inquest that both the consulting Psychiatrist and the Hospital's Manager said that Ms Grant was assessed upon admission to hospital in accordance with the national guidelines for the assessment for Deep vein thrombosis (DVT). As per the guidance criteria checklist, the clinician considered that there was no significant reduction in mobility, and therefore no further treatment or assessment for this condition was required. 2. Miss Grant had a significantly increased risk of DVT due to the effects of obesity and inactivity. In addition, there was a rare but recognised side effect of Risperidone.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. 1. You may wish to consider reviewing and revising the DVT national guidance checklist for long term patients with increased risk factors of obesity, immobility, and risperidone medication. 2. Specifically, when the sole criterion of immobility is met then there is no requirement for further examination or assessment by the clinician should be urgently reviewed.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 19 April 2021. 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; Family. 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	**19 February 2021** **Mr Zafar Siddique** **Senior Coroner** **Black Country Area**