Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1. **National Institute for Health and Care Excellence (NICE)**
2. **Family of the Deceased (copy)**
3. **Chief Coroner (copy)**
4. **Liverpool Heart and Chest Hospital (copy)**

1 CORONER

I am David LEWIS, Assistant Coroner for the area of Liverpool and Wirral

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 28/07/2020 I commenced an investigation into the death of Brian Jackson aged 64. The investigation concluded at the end of the inquest on 14 July 2021. The cause of death found was:

I a Neck compression

I b Ligature hanging

I c

II

The conclusion of the inquest was:

Whilst affected by ongoing symptoms associated with post-operative delirium the Deceased hanged himself in hospital.

4 CIRCUMSTANCES OF THE DEATH

Following major but successful heart surgery at Liverpool Heart and Chest Hospital, Thomas Drive, Broadgreen, Liverpool on16 July 2020 the Deceased developed symptoms consistent with delirium. On 23 July 2020 he was transferred from the Post-Operative Critical Care Unit to the Cedar Ward where (a few hours later) he used a ligature, which he had fashioned from pyjamas, to hang himself inside a locked bathroom. In doing so he sustained injuries from which he died at the scene, despite prompt medical attention.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows: (brief summary of matters of concern)

Following major heart surgery the Deceased spent a week on the Post-Operative Critical Care Unit, during which he presented intermittently with a range of symptoms which I was told in evidence constituted delirium, but were not consistently recognised or diagnosed as such by hospital staff. These symptoms were variously described as including confusion, agitation, severe paranoia and

anxiety.

On a number of occasions the Deceased's was assessed using the tool known as CAM-ICU, which I heard is a nationally recognised diagnostic tool, in widespread use across the country. ON each occasion the result was negative for the purpose of delirium diagnosis, contradicting the view expressed in court to the effect that a diagnosis of delirium was appropriate.

The hospital had its own policy concerning the management of patients at risk of delirium, the use of which depended in large measure upon a diagnosis being made. My impression was that the CAM-ICU results relied too heavily upon whether the patient was orientated in time and place, without allowing for a more complex cocktails of presentational symptoms to be taken into account.

I was told by senior hospital staff that their investigation has revealed shortcomings in the efficacy of the CAM-ICU tool, notably in assessing the risk faced by patients with 'hypo symptoms' of delirium, or patients who produce a negative CAM-ICU result but present with edidence of paranoia.

I heard details of extensive changes made by the hospital in its local arrangements and also that the hospital had approached NICE to ask if the CAM-ICU tool itself could be modified to take account of the lessons it had learnt in this case. I was told that the response from NICE was that use of the tool (and NICE guidance around this subject) had only recently been reviewed, in 2019, and is not to be reviewed again for some time.

I am concerned that across the country an assessment tool remains in widespread use despite the problems identified and is likely to remain so for the indefinite future, meaning that patients at risk of delirium are not diagnosed or treated optimally. The outcome of this cases illustrates the gravity of the harm that can result.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 08 September 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:

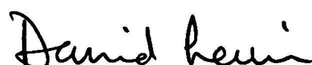
[REDACTED] (widow and next of kin of the deceased)

Liverpool Heart and Chest Hospital

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



David LEWIS

Assistant Coroner for
Liverpool and Wirral
Dated: 16 July 2021