Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 The Secretary of State for the Department of Health, Ministerial Correspondence and Public Enquiries Unit, Department of Health and Social Care, 39 Victoria Street, London, SW1H 0EU

1 CORONER

I am Simon MILBURN, Area Coroner for the area of Cambridgeshire and Peterborough

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 13.03.20 I commenced an Investigation into the death of Jonathan Mark Kingsman, aged 47 years. The Investigation concluded at the end of the Inquest on 12.07.21. The conclusion of the Inquest was that death was as a result of 'Natural Causes',

The medical cause of death being recorded as:

1a Pulmonary Thromboembolism;
1b Deep Vein Thrombosis;

4 CIRCUMSTANCES OF THE DEATH

Mr Kingsman was admitted to Fulbourn Hospital, Cambridge under s2 of the Mental Health Act 1983 on 26.01.21 where he remained until his death on 01.02.20. On admission it was reported that Mr Kingsman had not consumed any fluids for at least several hours.

The Doctor on call carried out an initial risk assessment using the Department of Health Template titled 'Risk Assessment for Venous Thromboembolism(VTE)' Gateway reference no: 10278. At 'Step 1' the document requires an assessment of the patient's anticipated mobility. Where the patient is 'NOT expected to have significantly reduced mobility relative to normal state' the assessor is directed to terminate the assessment. It was agreed evidence at the Inquest that Mr Kingsman fell into this category and likewise agreed that throughout his time in hospital that there were no changes to his mobility which would have prompted a renewed risk assessment.

The Inquest also heard evidence that 'immobility' was one of a number of potential risk factors for VTE. These included:- obesity; inherited blood clotting disorder; smoking; personal or family history of DVT or PE; dehydration; receipt of certain psychiatric medication(there are others listed on the risk assessment form itself). At least some of these potential risk factors may have been present in this case although on the evidence presented it was not possible to conclude to the required standard which, if any, may have played a part in Mr Kingsman's death. None of these risk factors was considered as part of the risk assessment process as Mr Kingsman did not get past 'Step 1' referred to above. Additional risk factors including those identified above are only considered at 'Step 2' in the risk assessment process. The evidence was that at no stage during his hospital admission was Mr Kingsman 'expected to have significantly reduced mobility relative to normal state' and therefore there was no stage at which these risk factors were prompted for consideration at 'Step 2' in the risk assessment process. Despite this Mr Kingsman died as a direct result of a

pulmonary thromboembolism caused by deep vein thrombosis.

The Inquest was also advised that the risk assessment form contains no guidance on its completion and no definitions of some of the terms used eg 'significantly reduced mobility compared to normal state';

5 CORONER'S CONCERNS

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

That the risk assessment requires no consideration of risk factors other than mobility unless 'Step 1' is passed regardless of the number of other risk factors which may be present and their severity – Mr Kingsman was not obviously at risk of 'significantly increased immobility compared to his normal state' but died as a result of a DVT/VTE nonetheless. It is reasonable to expect that others may be in the same position in the future;

The risk assessment form contains no guidance on its completion and no definition of certain terms.

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 **07 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] – Next of Kin

Cambridgeshire & Peterborough Foundation Trust – Mental Health Service Provider

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.

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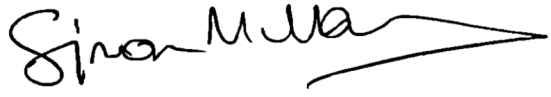

Simon MILBURN
Area Coroner for
Cambridgeshire and Peterborough
Dated: 13/07/2021