ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive of Kent & Medway Social Care Partnership Trust** **2. Chief Executive of Maidstone & Tunbridge Wells NHS Foundation Trust** **3. Secretary of State for Work & Pensions**
1	**CORONER** I am Sonia Hayes assistant coroner, for the coroner area of Mid Kent & Medway
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 29th October 2020 an investigation was commenced into the death of TERENCE TALBOT. The investigation concluded at the end of the inquest on 19th October 2021. The conclusion of the inquest was 1a Mulitorgan Failure 1b Empyema and Pneumonia 1c DRESS Syndrome Narrative Terence Talbot died from a complication of necessary medical treatment with prescription medication for his deteriorating mental health to which he suffered a very rare and severe allergic reaction with a poor prognosis. The absence of regular dermatology review, lack of application of emollients for whole body severe exfoliative dermatitis and food and fluid not being adequate to meet his needs leading to malnutrition amounted to a gross failure to provide basic medical care that would have prolonged but probably would not have saved his life.
4	**CIRCUMSTANCES OF DEATH** Terence Talbot died at Maidstone & Tunbridge Wells NHS Trust on 9th April 2020 of Multiorgan Failure due to Empyema and Pneumonia caused by DRESS Syndrome diagnosed on 31st October 2019 as a consequence of a severe reaction to therapeutic prescription of Olanzapine and Risperidone medication to treat Bipolar Affective Disorder in September and October 2019 whilst he was detained under the Mental Health Act. Terence had multiple discharges from acute hospital following admission for symptoms of DRESS syndrome with severe exfoliative dermatitis. Prescribed emollients were recorded as self-administered although Mr Talbot could not apply them effectively himself. Food, fluid and nutrition was not adequate to meet Mr. Talbot's needs and nasogastric feeding was commenced on 26th February 2020 after escalation from the Discharge Liaison Nurse and a best interest meeting. Mr Talbot's sister persuaded him to co-operate although this feeding did not meet his needs. Mr Talbot was cachexic with deranged electrolytes and suffered malnutrition. He was treated for aspiration pneumonia on 3rd March and suffered a left sided pneumothorax on 4th March treated with drain insertion. Mr Talbot was diagnosed with empyema treated with antibiotics and his DRESS Syndrome failed to improve and he was placed on end-of-life care.

CORONERS 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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

Evidence was heard at the Inquest that Mr Talbot suffered an exceptionally rare life-threatening reaction to prescription medication for Bipolar Affective Disorder whilst he was detained under the Mental Health Act that included whole body severe exfoliative dermatitis. Mr Talbot was discharged from acute hospital to his psychiatric hospital several times within the first week of his diagnosis. He was readmitted to the acute hospital as his condition deteriorated. There was a lack of formal mental capacity assessments for his capacity to consent to and/or refuse treatment. There was an absence of regular dermatology review and lack of application of emollients. Food and fluid was not adequate to meet his needs leading to malnutrition and continued despite the insertion of a nasogastric tube in February.

The **MATTERS OF CONCERN** are as follows. –

(1) Chief Executive of Kent & Medway Social Care Partnership Trust on concerns relating to issues that Terence Talbot had begun to exhibit symptoms of a depressive phase of his Bipolar Affective Disorder just prior to his discharge back to psychiatric hospital at the end of November 2019. Issues relating to capacity to make specific decisions in relation to Terence Talbot's care and treatment were not all subjected to formal Mental Capacity Act assessments when he was refusing medical interventions that were in his best interests in the clinical picture of an extremely rare and complex medical diagnosis that arose due to his reaction to prescribed medication to treat his mental disorder and evidence of increasing low mood and symptoms consistent with depression.

(2) **Chief Executive of Maidstone & Tunbridge Wells NHS Foundation Trust** as to the lack of consideration of specialty dermatology referral with deteriorating severe exfoliative dermatitis in a rare and complex diagnosis. There was a lack of regular dietitian input with malnutrition. The evidence was the focus was on problems relating to discharge rather than treatment during multidisciplinary meetings. Issues relating to capacity to consent to, or refuse treatment were not not all subjected to mental capacity assessments.

(3) **Secretary of Work & Pensions** to improve public health, welfare and safety due to a concern that circumstances creating a risk of further deaths may occur, or will continue to exist, in the future. The Department of Work & Pensions required Terence Talbot to attend in person to make a claim for benefits rather than accept an electronic claim. I heard from all the doctors and a senior nurse in this case who have a considerable experience across a range of specialties and across several different NHS Trusts that they have never experienced nor heard of a case where a severely ill inpatient was required by the Department of Work & Pensions to leave hospital to attend its offices in person to make a claim for welfare benefits. Terence Talbot was suffering with a mental disorder and an exceptionally rare and complex disease with a risk of death and suffering severe exfoliative dermatitis that rendered him very vulnerable to infection.

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 28th January 2022. 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] (Sister), Dr [redacted], Kent & Medway Social Care Partnership Trust, Maidstone & Tunbridge Wells NHS Foundation Trust. I have also sent it to CQC who may find it useful or of interest. I am under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	Signature: S. M. Hayes Sonia Hayes Assistant Coroner **Mid Kent and Medway** 3rd December 2021