REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Dr [redacted], Chief Executive Nottinghamshire Healthcare NHS Foundation Trust**
1	**CORONER** I am Dr Elizabeth Didcock, Assistant Coroner, for the coroner area of Nottinghamshire
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 7th May 2021, I commenced an investigation into the death of Michelle Whitehead, aged forty five years. The investigation remains open, and the case will come to an Inquest to be held with a Jury, in the next 12 to 18 months I have taken the unusual step of issuing this report at this time, as I consider the risk of future deaths, if there is no mitigation of risk in the relation to the issues identified below, to be high.
4	**CIRCUMSTANCES OF THE DEATH** Michelle Whitehead died from a hypoxic brain injury, on the 7th May 2021. The Post mortem undertaken on the 18th May 2021 by Dr [redacted], Consultant Pathologist, identifies the hypoxic brain injury, but is unable to establish the cause of the hypoxic damage. She was on a Section 2 of the Mental Health Act (1983), at the Millbrook Unit when the incident below occurred, with the section rescinded only because she was unconscious on ITU at Kings Mill Hospital just prior to her death. The Serious Incident report dated 4.11.21, together with the staff statements provided thus far, reveal a very worrying picture. Mrs Whitehead was formally admitted to Lucy Wade ward at Millbrook Mental Health Unit under Section 2 on the evening of 3 May 2021 following a deterioration in her mental health. On 5 May 2021, her mental health deteriorated further, and she required medication to manage her presentation and risk to self and others. She was likely administered [redacted] diazepam orally at 16:00 (although there is conflicting evidence as to the drug given and the dose given) and later at 16:20, [redacted] lorazepam was administered IM. She was monitored initially with appropriate observations, but these were discontinued too soon.

	At approximately 20:45 staff noticed a change in her breathing pattern which led to initiation of physical monitoring, but by this time her respiration rate was slow, and her oxygen SATS also low. The doctor was called, but did not respond, and it was a second night doctor that attended just after 9pm. Mrs Whitehead was reported to have a swollen face, lips, and was shallow breathing with difficulty. There was also a drop in oxygen saturation levels, so she was administered adrenaline.- The treating doctor wondered if her presentation may represent anaphylaxis, as she had a history of allergies, but there were no signs of allergy when the paramedics arrived, nor at post mortem examination. Following this there was not much improvement in physical parameters, so another dose of adrenaline was given, and an iGel was inserted to assist with breathing. The paramedics arrived on the ward, delayed by at least 10 minutes because they could not get into the Unit. They also had to ring back as the nurse contacting 999 had cleared the line. Mrs Whitehead was intubated and transferred to Kings Mill Hospital and admitted to the Intensive Care Unit (ICU). She died on 7.5.21.
5	**CORONER'S CONCERNS** During the course of the Investigation 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. Unclear dose/type of sedation medication given, possible excess dose given, poor documentation 2. Delayed recognition of Mrs Whitehead's declining condition 3. No medical clerking from admission until her collapse 4. No Consultant involvement after admission 5. Inability to reach Duty Doctor for deteriorating patient 6. Delay in calling paramedics 7. Delay in Paramedics gaining access to the ward Many of these issues have been the subject of scrutiny in at least two previous Inquests, that have followed deaths on inpatient wards of the Trust. I have received reassurance during these Hearings that the issues have been addressed, but this case illustrates that they clearly remain. The issues are very serious in my view.
1	**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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by the 16th March 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] 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	**19th January 2022** **Dr E A Didcock**