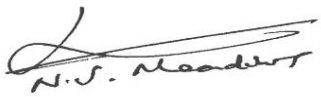
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • Dr. [redacted] Medical Director GMMH NHS Trust Trust HQ, Bury New Road, Prestwich, Manchester M25 3BL Copied for interest to: • [redacted]– the deceased's sister • [redacted] - the deceased's sister • The CQC
1	**CORONER** I am: Senior Coroner Nigel Meadows Senior Coroner for Manchester City Area HM Coroner's Court and Office Exchange Floor The Royal Exchange Building Cross Street Manchester M2 7EF
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 4th March 2020 I commenced an investigation into the death of. The investigation concluded on the 29th March 2022. The Conclusion of the inquest was**: Narrative Conclusion: The Deceased suffered from a chronic mental disorder and serious self-neglect. After compulsory admission to hospital under the Mental Health Act there was a gross failure to provide her with**

	basic medical care which contributed to her death and it was possible that if she had received that care and VTE prophylaxis treatment she would not have developed a pulmonary thromboembolism and died.
4	**CIRCUMSTANCES OF THE DEATH** The deceased suffered with mental health problems since childhood and was considered originally to have a personality disorder. She was treated by mental health services for many years and had several inpatient admissions some of which were compulsory. She was eventually diagnosed with psychotic depression and was treated with antipsychotic and antidepressant medication. In addition, she also required considerable support for day-to-day living and had an above normal BMI caused by her antipsychotic medication. In December 2019 and in January 2020 she was noted to be self-neglecting and only partially engaging with mental health and primary care services. On the 8 January 2020 she was visited by her care coordinator and a psychiatrist who was unfamiliar with her background. She presented as being malodorous, dishevelled and with unwashed hair. Her partner was present, and he was noted to be abrupt and hostile. No appropriate safeguarding referrals had been made and no comprehensive MDT discussion took place. On 15 January 2020 she was reviewed by a consultant psychiatrist who considered that she did require an admission to hospital and had the capacity to consent to this is as a voluntary patient but there was no available bed. On 24 January 2020 she refused voluntary admission and a recommendation was made for a section 2 MHA. However, there was no AMPH capacity to progress this, but she was subsequently detained under the MHA on 27 January 2020 at Park House Psychiatric unit, Manchester. On admission she was found to be significantly malodorous and have several long-standing serious deep infected ulcers/wounds and had to be transferred to the acute hospital for assessment and treatment. Her condition gradually improved and she was given prophylactic venous thromboembolism (VTE) medication until she was medically fit enough to be discharged back to the psychiatric unit on 12 February 2020. Subsequently, on readmission despite discharge information from the acute hospital that she had been treated with VTE Prophylaxis there was a failure to undertake a VTE risk assessment in accordance with the detaining authorities' policy/protocol despite her fulfilling several trigger criteria. There was a failure to monitor her condition and make appropriate records or an action/management plan. She did not have further mental capacity assessments. On the 19 February 2020 she was detained under S. 3 MHA. On the morning of 23 February 2020, she had a cardio-respiratory arrest and was resuscitated for a brief period of time before being taken to the emergency department of North Manchester General Hospital where further attempts at resuscitation proved unsuccessful and she was pronounced dead. This was caused by her suffering a pulmonary thromboembolism. The GMMH serious incident investigation failed to establish whether the Responsible Clinician, Jr. Doctors or nursing staff were aware of the trusts VTE policy and if not, why not. Furthermore, if they were aware of it why was it not complied with. Nor if there was an awareness and compliance with the policy Trust wide. It also failed to identify, acknowledge or apparently be aware of the death of a patient in 2016 from a VTE at Park House unit which subsequently led to the amended and updated VTE policy being introduced which was not complied with.

	The investigation failed to establish why no formal mental capacity assessments were undertaken and recorded or why there was not a reassessment of the VTE risks. The investigation failed to identify, acknowledge or apparently be aware of the death of another patient in 2016 from a VTE at Park House unit which subsequently led to the amended and updated VTE policy being introduced that should have been complied with in relation to the deceased's care.
5	**CORONER'S 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 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. There was a lack of appropriate safeguarding review, Senior clinical oversight as well as necessary MDT meetings and actions to be completed. 2. It did not appear that all permanent or locum clinical and nursing staff Trust wide were aware of the VTE policy and how it should be implemented including initial assessments and reassessments of the risks as well as consequent medical management. 3. There was no regular audit of compliance with the VTE policy. 4. There was no training programme to ensure familiarity and compliance.
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 the 27th June 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 Interested Persons. I have also sent it to organisations who may find it useful or of interest. 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	**DATE: 1st April 2022** **Mr Nigel Meadows** HM Senior Coroner  Manchester City Area **Signed:**