	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chief Executive of Kent and Medway NHS Social Care Partnership Trust** **2. [redacted], Corporate Director - Adult Social Care and Health Kent County Council**
1	**CORONER** I am Joanne Andrews, Area Coroner, for the coroner area of North East Kent
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 6 May 2021 I commenced an investigation into the death of Pauline Keen, aged 72. The investigation concluded at the end of the inquest on 28 April 2022. The conclusion of the inquest was that Mrs Keen died from 1(a) Multiorgan Failure (b) Sepsis (c) Bronchopneumonia 2. Depression, Hypertension, Atrial fibrillation, Asthma, Acetabular Fracture The jury recorded a narrative conclusion to the inquest as follows: Pauline Keen suffered a fall in her home in January 2021. This led to a series of events which ultimately led to her death on 24th April 2021. Following her fall, she was admitted to hospital where she developed the first signs of mental distress. Due to immobility, she was transferred to the Harrier Lodge Care Home on 26th February 2021. Due to a lack of general nursing beds, she was put in a dementia ward where she needed to go through a period of isolation. During this time, it was noted that her mental health continued to decline, but at first this was put down to settling in issues. Once the isolation period was over Pauline's mental state continued to decline and she started refusing food, fluid and medication. It was decided that she would need to be referred for admission in a mental health ward. The Clinical Nurse Specialist for Older People at Kent Community Health Care Trust was advised of this by the care home manager on 30th March. The case was referred to a consultant at KMPT and it was confirmed that she should be moved to a mental health unit. At the time of this assessment it was thought no appropriate beds were available, but due to declining physical health, she

	was transferred to A&E at QEQM on 17th April 2021 where her condition continued to deteriorate.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Keen fell at home on 17 January 2021 in which she sustained an acetabular fracture. She attended hospital but was not admitted until 17 February 2021. When she was medically fit for discharge, she was discharged to Harrier Lodge Care Home on 26 February 2021. During her admission to the hospital there were concerns about her mental health, but she was not seen by Kent and Medway Social Care Partnership Trust ('KMPT'). After discharge to Harrier Lodge he mental health deteriorated and she was referred to KMPT for assessment. This referral was made on 30 March 2021 and Mrs Keen was seen by a Trainee Doctor on 13 April 2021 who determined that she needed assessment under the Mental Health Act. As such, Dr [redacted] from KMPT attended her on the following day and made a medical recommendation that Mrs Keen should be detained under the Mental Health Act. She notified the Approved Mental Health Practitioners Service at Kent County Council that Mrs Keen would need assessment and telephoned them to ask that she be seen. On 16 April 2021, an Approved Mental Health Practitioner, [redacted], was allocated Mrs Keen's case but was not aware of this until 17 April 2021. On 17 April 2021, [redacted] made arrangements for himself and Dr [redacted] (an independent section 12 doctor) to attend Mrs Keen for assessment. The outcome of the assessment was that Mrs Keen should be admitted. The evidence I heard was that [redacted] had been informed at some point that day that there was no bed available for Mrs Keen in the event that the assessment concluded that she should be admitted. He could not confirm who or when this conversation took place save to say that it would be his normal practice to contact the Bed Management Team/Patient Flow Team at KMPT before and after the assessment. He stated that the fact that his report noted that there was no bed demonstrated that the conversation(s) must have occurred as he would have no other way of obtaining that information. [redacted] stated in his evidence that the Bed Management Team/Patient Flow Team knew that Mrs Keen needed a bed and that he was not contacted at any time that a bed was available as he would have otherwise completed the application. The evidence from the Bed Management Team/Patient Flow Team at KMPT was that the obligation was on the AMHP after the assessment to contact them and advise them of the outcome and this was not done. The evidence was that there was a bed for Mrs Keen on 17 April 2021 and that the AMHP Shift Manager who attended the meeting on 17 April in the morning was aware of the intention that a bed would be available later

	that day. [redacted] was clear in his evidence that he was not aware of this. The evidence from the Manager of the Patient Flow Service at KMPT of which the Bed Management Team forms a part and the Head of the AMHP service at Kent County Council was that there was no written agreement in place as to who was responsible for communicating that a bed was still required for a patient between the two organisations. The evidence from [redacted] was that he considered that a bed was required unless he communicated to KMPT to the contrary whereas KMPT considered it was the responsibility of the AMHP to contact them after an assessment to confirm the bed was required. The evidence from the AMHP service manager was that the process would change depending on who the Patient Flow Manager was on a particular day when this was out of hours or on a weekend. The evidence was that there is now a protocol in place which sets this out but both organisation's witnesses agreed that this needs to have the force of a policy which it does not. It was stated that both organisations intend that this should be translated into a formal policy so that this could be disseminated among the staff of both organisations, but this has not been started or completed.
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 could 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 is no policy in place between KMPT and Kent County Council AMHP service as to how the organisations communicate with one another to ensure that applications under the Mental Health Act are made as soon as reasonably practicable without delay to patients.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisations 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 18 July 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]. I am also 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	**12 May 2022** J. Andrews