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 TO BE SENT TO:** **1. Chief Executive Partnerships in Care, Joy Chamberlain** **2. Chief Executive South London and Maudsley NHS Foundation Trust,** [redacted]
1	**CORONER** I am David Skipp Assistant Coroner, for the Coroner area of West Sussex
2	**CORONERS 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 8th May 2012 I commenced an investigation into the death of Natasha Raghoo born 24th February1978, being 34 years of age. The investigation concluded at the end of the inquest on 20th February 2014.The conclusion by a jury was that Natasha Yvonne Raghoo died on the 5th May 2012 in the Michael Shepherd ward at the Dene Hospital , Hassocks, West Sussex. Natasha Raghoo was detained under Section 2 of the Mental Health Act. Based on the evidence we agree the cause of death to be anaphylactic shock caused by an unknown allergen.
4	**CIRCUMSTANCES OF DEATH** On 25th April 2012 Natasha Raghoo was admitted to the Dene Hospital Hassocks as an informal patient. She had a history of Bi Polar disorder and had required admission to hospital in the past. Recognising the signs of a relapse she asked for help and the Home treatment team from the South London and Maudsley NHS foundation Trust (SLAM) were to provide medical care in the family environment. Circumstances led to a section 136 then transfer, from the Maudsley, via Queen Elizabeth Hospital Woolwich to The Dene. On the 26th April she was placed on a 72 hour holding section 5(2) of the Mental Health Act and on the 27th April she was detained on section 2 of the Mental Health Act. Whilst at The Dene, Miss Raghoo was found to have a raised blood pressure for which she received treatment instituted at the suggestion of a medical registrar at the Princess Royal Hospital Haywards Heath. She was also known to be atopic with allergies to nuts and possibly fish. The symptoms of agitation, distress, delusions and poor sleeping led to the introduction of antipsychotic medication and sedatives. There were also episodes of signs of allergic reactions and possible asthma. Natasha was found unresponsive in her bed on the 5th May 2012 at approximately 06.30 to 06.45 .Resuscitation attempts by both staff and paramedics were

	unsuccessful. The cause of death was given as anaphylactic shock.
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. During the course of the evidence, concern was expressed concerning the training that staff had received in the techniques of cardio pulmonary resuscitation and the use of the defibrillator. The latter was reported not to have been used by hospital staff although available on the ward. 2. Physical observations of blood pressure, pulse and temperature were sporadic and few in number. This was cause for concern as Natasha had a raised blood pressure and had been commenced on treatment, Observations stopped two days prior to death and no member of staff was able to explain who was responsible for this action. 3. Whilst under the care of the Dene,and on antipsychotic drugs and with a raised blood pressure an electrocardiogram was not carried out because all routine ECGs are performed by a visiting nurse from a General Practitioners surgery on a set day of the week. An ECG machine is available within the hospital but is not routinely used. 4. Staff handovers occur twice daily in the morning and evening. Those finishing a shift hand on information about the patients to the incoming shift. It was apparent that communication was inconsistent, particularly when bank or agency staff were involved. 5. Communications between staff and family were haphazard the policy of involving family in care planning was not clear. 6. The policy of access to GP services was not clear leading to misunderstanding by the Princess Royal as to where to send a report. 7. Unclear as to whether checking to ensure that when using agency staff they have not already worked a shift elsewhere that day. 8. Obtaining records particularly from community services involved with the care of the patient was difficult and slow. 9. The policy on length of time staff are expected to conduct observations, and the quality of handover from one member of staff to another.
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 30th April 2014. 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, Natasha Raghoo's mother c/o Bindmans LLP who are representing the family of Miss Raghoo. 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 of the publication of your response by the Chief Coroner.
9	**DATE: 6/03/2014 Dr David Skipp Assistant Coroner West Sussex**