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. **Family** 2. **Care Quality Commission** 3. **Chief Executive Oxleas NHS Foundation Trust** 4. **Secretary of State for Health**
1	**CORONER** I am Sonia Hayes, assistant coroner, for the coroner area of South London
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 27th September 2016 the Senior Coroner commenced an investigation into the death of Julia Jane MacPherson age 54. The investigation concluded at the end of the inquest on 24th November 2017. The conclusion of the inquest was the medical cause of death being 1a Upper Airway Obstruction 1b underlying swallowing difficulties 1c Extrapyramidal symptoms of medication muscle rigidity and tachycardia.
4	**CIRCUMSTANCES OF THE DEATH** An informal patient at Oxleas NHS Foundation Trust with a history of personality disorder, anxiety and self-harm treated as an informal patient with medication that caused extra pyramidal symptoms. She suffered swallowing difficulties and collapsed in the community with food bolus and vomitus in the throat. London Ambulance Service attended but PEA persisted despite advanced CPR and reversal of potential causes on 18th May. Confirmed life extinct at 12:15.
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) It was agreed that Julia usually had a comprehensive understanding of her mental health and medications and was an informal patient consenting to her care and treatment. Quetapine had been stopped due to concerns about seizures. A trial of Clozapine was commenced on 18 January 2016, prescribed off licence and Julia and her family raised concerns with her clinicians who had made adjustments to her dose but she continued to experience side effects that she found difficult to tolerate. She had a home visit with her mother on Sunday 15th May and despite usually being self-caring, she needed full assistance in her care and she spent most of the visit in bed. Significant concerns were raised by her mother that Julia was not well enough to be taken out, that she had no

	comprehension of her medication, that she appeared confused and that her memory and speech appeared to be affected. Her mother left a note with nursing staff requesting an immediate medical review by her Responsible Clinician as she had no other way of contacting him, however: (a) This review did not take place and her Responsible Clinician did not see this note until the inquest. (b) Julia was not reviewed on 16th May. (c) A formal review of her mental capacity to consent to her treatment did not take place following concerns raised by her mother on 15th May or when Hospital staff noted that Julia was very confused on 17th May. (2) Evidence at the inquest was that hospital staff did not regularly read clinical and nursing entries in patient medical records. (3) Medical records concerning discussions about her consent to prescription off licence medication for her mental health were missing or incomplete even though numerous concerns about her Clozapine and polypharmacy, over sedation and confusion were raised. (4) NICE guidelines for the prescription of off licenced medicines was not followed. (5) Adult patients sectioned under the Mental Health Act have statutory forms that lists all psychiatric medication that can be administered either on T2 (patient consents) or on T3 (patient does not consent) which requires the approval of a Second Opinion Appointed Doctor. There is no statutory process for recording consent to medication for informal patients.
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 6th April 2018. 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: the family, the CEO of Oxleas NHS Foundation Trust and the Care Quality Commission. I have also sent it to the Secretary of State for Health 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	**Sonia Hayes** - SM Hayes