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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Oxleas NHS Foundation Trust**
1	**CORONER** I am Roger Hatch Senior Coroner for **North West 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 13th December 2017 I commenced an investigation into the death of Jennifer Lewis. The investigation concluded at the end of the inquest 29th March 2019. The conclusion of the inquest was Jennifer Lewis died at the Darent Valley Hospital, Darenth Wood Road, Darenth on the thirty-first July 2017 as a result of malnutrition due to inadequate provision and intake of sufficient nourishment and nutrition furthered by an inability to appropriate the necessary medical intervention whilst at the Bracton Centre.
4	**CIRCUMSTANCES OF THE DEATH** Ms Lewis was brought to the emergency department on 21/07/2017 via ambulance from the Bracton Centre at Oxleas NHS Trust. The admission history states that the nursing staff at the Bracton Centre had been concerned about the poor intake, diarrhoea, confusion, and hypotension. On observation she had low blood pressure (99/61mmhg), was dehydrated, and tachycardic. She appeared unkempt, lethargic and had reduced responsiveness. The history shows that diarrhoea started two days prior to admission, and she had a gradual decline in mobility over the two day period and has been noted to be less talkative than normal. Leg oedema was noted and a healed left leg superficial ulcer. Working diagnosis of dehydration, sepsis (likely urinary), anaemia, and muteness (long standing) was made. She was treated with IV fluids, dietician referral, and Intravenous antibiotics. At 9.45 on 20 July 2017 the patient was reviewed and it was noticed that the patient had an unidentified feeding tube (later established to be a surgically inserted PEG) institute which was tied up and not in active use. Further investigation is documented on 24 July that the PEG tube was used for 2 years post insertion, and not used since that time. It is documented that the patient had lost 10kgs since March 2017. The patient had been managed at the Whittington Hospital and Queen Elizabeth Hospital prior to admission to DVH. CT CAP on 21 July 2017 revealed extensive ascites affecting all peritoneal compartments, with associated oedema of the colon, bilateral pleural effusions and hepatic varices. CT head scan 21 July NAD. Medical emergency call was placed on 21 July 2017 due to raised heart rate and low BP. Impression was

	that she was severely dehydrated, and hypoglycaemic secondary to malnutrition. She was treated with 10% Glucose (IV) IV Pabrinex, and Iv fluids bolus? to keep her blood pressure above 100mmhg systolic. 26th July 2017 reviewed and discussed the possibility of needing parenteral nutrition (PN) as not improving clinically and not able to receive oral/enteral nutrition. 28th July 2017 A central line was inserted on and she was given Total parenteral Nutarian (TPN). This was started at 10mls per hour given the risk of refeeding syndrome. The decision to commence PN was discussed with and agreed with psychiatry consultant. She became breathless after the commencement of the TPN. A CT scan of the thorax was undertaken (post CVP line insertion and commencement of PN) this revealed a pneumonia. She was reviewed by the on call Psychiatric liaison team (consultant Psychiatrists on 24 July 2017. The patient was thought to be Jehovah witness and there was differing information provided by the family members about whether the patient was Jehovah Witness or Presbyterian. Documented in the notes not to give blood products unless the patient was haemodynamically unstable or evidence that she was actively bleeding, and must have consultant approval to do so. The patient continued to deteriorate and was reviewed by the ITU team on 28 July 2017. In relation to chest infection plan to move to medical high dependency department and she was not considered a candidate for ITU care. The family were aware and in agreement with this decision. Referral as the patient was being cared for under section 3 of the Mental Health Act Safeguarding concerns (the patient was malnourished and unkempt on admission)
5	**<u>CORONER'S CONCERNS</u>** 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) The failure to arrange consultation between the mental health doctors and the doctors responsible for her physical health (2) The failure to provide suitable or adequate care for her needs. (3) The failure to provide appropriate care at the Centre.

6	**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 10th June 2019, 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 – Lewisham & Greenwich NHS Trust and Dartford & Gravesham NHS Trust.I have also sent it to [redacted] 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	15th April 2019 Signature:  Roger Hatch Senior Coroner **North West Kent**