**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS**

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**(1) Medical Director - Manchester University NHS Foundation Trust** |
| 1 | **CORONER**<br><br>I am, Rachel Galloway, Assistant Coroner for the Coroner Area of Manchester City. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On the 23rd November 2016 an investigation was commenced into the death of Charlotte Elizabeth Jacobs, aged 79 years, born on the 12th June 1937.<br><br>The investigation concluded following a 3-day inquest, with a Jury, on the 14th October 2019.<br><br>The Jury recorded the Medical Cause of Death as:<br><br>1a Congestive Cardiac Failure<br>1b Ischaemic and Hypertensive Heart Disease, Cerebrovascular Infarction and Deep Tissue Injury following a fall<br><br>II Diabetes (Type II), Severe Depression<br><br>The conclusion of the Jury at the inquest was:<br><br>Narrative Conclusion: Charlotte Jacobs died as a consequence of heart failure arising from heart-related disease, a cerebrovascular infarction and a deep tissue injury sustained in a fall, on a background of mental illness and naturally occurring disease. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>The Jury recorded as follows:<br>*"On the 11th October 2016, Charlotte Jacobs suffered an accidental fall at home. She suffered a deep tissue injury to her sacrum as a result of the fall and the unknown period of time she remained on the floor prior to being found. Charlotte Jacobs was found on the evening of the 11th October 2016. An ambulance was called and she was taken to Manchester Royal Infirmary and admitted for assessment. She was later admitted to Ward 46. Providing care and treatment to Charlotte Jacobs was challenging due to difficulty in cannulating combined with Ms Jacobs' refusal to accept fluids and nutrition due to underlying mental illness. On the 28th October 2016, Charlotte Jacobs was discharged from Manchester Royal Infirmary and transferred to Maple Ward at Park House Psychiatric Hospital.*<br><br>*On arrival, she was noted to be severely unwell. It was noted that the deep tissue injury had broken down, leading to a significant sacral ulcer. Charlotte Jacobs was transferred by ambulance to North Manchester General Hospital where investigations confirmed that she had suffered a stroke. Her condition declined and Charlotte Jacobs died at 4.20 a.m. on the 31st October 2016 at North Manchester General Hospital".* |

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| | During the course of the inquest, evidence was heard that Doctors and Nurses on Ward 46 at Manchester Royal Infirmary did not carry out a capacity assessment on Ms Jacobs. Therefore, consideration was not given to Ms Jacobs' ability to consent to and/or refuse nutrition, fluids and/or medical treatment. She was discharged to Maple Ward on the 28th October 2016 in the knowledge that she had significantly deranged blood test results and remained physically very unwell. The main reason for this transfer appeared to be the difficulty that staff were having in ensuring compliance with treatment, fluids and nutrition (Ms Jacobs was refusing nutrition, fluids and medication and was regularly pulling out her intravenous line). It was hoped that staff on Maple Ward would be in a better position to manage these difficulties and encourage compliance with treatment. Charlotte Jacobs was sectioned under section 2 of the Mental Health Act on the 28th October 2016 prior to her transfer to Maple Ward at Park House Hospital. After she arrived at Park House, she was taken by ambulance to North Manchester General Hospital.<br><br>Charlotte Jacobs had a recent history of mental illness and had been under the care of mental health services within the community. A few days prior to her admission to Manchester Royal Infirmary on the 11th October 2016, an attempt had been made to assess her under the Mental Health Act 1983 at her home address. She had not permitted the 2 doctors and/or the Approved Mental Health Professional to enter her address. They had left and planned to apply for and obtain a warrant in order to access her property and assess her further. Prior to that occurring, Ms Jacobs had a fall at her home and was admitted to Manchester Royal Infirmary on the 11th October 2016.<br><br>Staff on Ward 46 at Manchester Royal Infirmary did not carry out any assessment of Ms Jacobs in accordance with the Mental Capacity Act, as they wrongly assumed that the Psychiatrist (or Psychiatric Team) would deal with matters of this nature. The evidence suggested that the outcome for Ms Jacobs *might* have been different, had she not been transferred to Maple Ward on the 28th October 2016. Instead, consideration should have been given to assessment of her capacity to refuse treatment, medication, fluids and nutrition. In the event that she had been found to lack capacity to refuse the aforementioned matters, further steps could have been taken at Manchester Royal Infirmary to make decisions in her best interests. The evidence was that, on the balance of probabilities the outcome would not have been different.<br><br>Manchester University NHS Foundation Trust carried out an internal investigation following Ms Jacobs' death. It was concluded that the transfer should not have taken place on the 28th October 2016 and that nursing and medical staff did not carry out any capacity assessment. |
| 5 | **CORONER'S CONCERNS**<br><br>During 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.<br><br>During the inquest, evidence was heard that:<br><br>1. The Consultant in charge of Ms Jacobs' care (who authorised Ms Jacobs' discharge on the 28th October 2016 to Maple Ward) indicated that – if similar circumstances arose again – he would make the same decision to transfer a patient to the Psychiatric Unit, despite the findings of the internal trust investigation that the discharge/transfer to Maple Ward should not have taken place.<br><br>2. The Consultant in charge of Ms Jacobs' care still did not appear to understand that it was his role (and the role of those involved in treatment of Ms Jacobs' physical illness) to consider whether a capacity assessment was required and to carry that out. This was not the role of the Psychiatric team. |

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| | 3. The Consultant in charge of Ms Jacobs' care and the Ward Manager for Ward 46 (at the time in 2016) did not appear to be aware of the findings of the Trust's internal investigation.<br><br>4. Whilst I was informed that steps were being taken to put together guidance and a protocol for transfers of patients from Manchester Royal Infirmary to Park House, this had not been completed (despite Ms Jacobs' death occurring some time ago in 2016).<br><br>In light of this evidence, I am concerned that there could be further inappropriate discharges/transfers from Ward 46 and/or from Manchester Royal Infirmary generally, leading to a risk of future deaths. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by **8th January 2020**. I, the assistant coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and the following Persons:<br><br>(1) [redacted]s – niece<br>(2) Medical Director – Greater Manchester Mental Health<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 assistant coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner. |
| 9 | **Dated - 7th November 2019** |
| | **Signed:**<br><br>  <br><br>**Rachel Galloway**<br>HM Assistant Coroner |