Regulation 28: REPORT TO PREVENT FUTURE DEATHS

.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1. **Chief Executive**
   The Queen Elizabeth Hospital
   NHS Trust
   Gayton Road
   King's Lynn
   Norfolk
   PE30 4ET

2. **Chief Executive**
   Norfolk and Suffolk NHS Foundation Trust
   1st Floor Admin
   Hellesdon Hospital
   Drayton High Road
   Norwich
   NR6 5BE

1. CORONER

I am Yvonne BLAKE, Area Coroner for the area of Norfolk

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 07/04/2021 I commenced an investigation into the death of Terence Robert TUTTLE aged 65. The investigation concluded at the end of the inquest on 29/07/2021. The medical cause of death was:

1a) Frailty Syndrome
1b) Idiopathic Pulmonary Fibrosis and Schizophrenia
1c)
1d)
2 Chronic Obstructive Pulmonary Disease

The conclusion of the inquest was: Mr Terence Tuttle was admitted to hospital after testing positive for covid in January 2021. He usually resided in a care home, had known mental health illness but had been stable on anti-psychotics for many years. He was treated appropriately for acute kidney injury and pneumonia and had food and fluid record charts. Despite these demonstrating poor oral intake no prompt action was taken. It was after a review by the mental health liaison team that decisions were taken relating to nutrition and diet. Mr Tuttle had lost a significant amount of weight which contributed to his poor condition post covid. He had also been found to have a bleeding duodenal ulcer and complained about his stomach being uncomfortable. He was transferred to a different nursing home after a best interests meeting was held which decided that he had capacity to risk feed. He died 3 days later at the nursing home.

4. CIRCUMSTANCES OF THE DEATH

Mr Tuttle lived and was cared for in a care home. He had a longstanding diagnosis of schizophrenia which had been stable for many years on anti-psychotic medication. In January 2021 he was admitted to a general hospital a week after testing positive for Covid-19. On admission he had an acute kidney injury which was treated, and pneumonia. He was also found to have a bleeding duodenal ulcer for which he received a blood transfusion and a proton pump inhibitor. He had been complaining of abdominal discomfort. He had diet and fluid record charts which demonstrated that he was not having adequate oral intake. Nothing was done about this and he lost 10kgs in weight over a 3- week period.

He had a mental health review and was prescribed antidepressants. It appears some encouragement to take food and fluids was made but he was not seen promptly by the dieticians and he was weakened and malnourished when he was assessed. He was not felt to have capacity to refuse food initially, but this opinion was changed later. Mr Tuttle was also refusing medication including anti-psychotics. His family were refused permission to visit. They had offered to come and try to persuade him to eat. By the time he had been properly assessed he was weak after his pneumonia and lack of adequate food and fluids. His appetite was gone, and he continued to refuse food. A best interests meeting was held, and it was agreed he had capacity and could risk feed since he refused naso-gastric feeding. A new nursing home placement was found because he had increased care needs and he was transferred there approximately 50 miles away from his family who had always been involved in his care. He died 3 days later. The hospital conducted an investigation but concluded no major harm occurred to the patient due to lack of care. Their recommendations included actions which should already be in place as a matter of common sense and do not address at all the difficulties in looking after a mentally unwell patient in an acute setting. There were no prompt MH or dietician assessments. There was confusion/lack of knowledge around The Mental Capacity Act and associated paperwork. There was no focussed consistent approach to his overall care and symptoms.

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.Lack of proper dietician assessment and mental health review at an early stage.
2.Inaction when Mr Tuttle was losing weight even though his intake was recorded no-one acted upon this.
3.Ability to assess Mr Tuttle adequately under the Mental Capacity Act.
4.Inability to care for a mentally unwell patient with physical health problems, including gastric problems, who is refusing to eat.
5.Refusal to include family members in caring for (after over 20 years in a care home) a patient who was in unfamiliar surroundings and their better knowledge of his usual presentation.
6. Apparent lack of recognition that serious harm did occur for this patient who was described as appearing cachexic.

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 30 September 2021. 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] - Brother

I have also sent it to :

Care Quality Commission (CQC)
Healthwatch (Norfolk)
Norfolk and Waveney MIND

who may find it useful or of interest.

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. Dated: 09 August 2021

Yvonne BLAKE
Area Coroner for Norfolk
Norfolk Coroner Service
County Hall
Martineau Lane
Norwich NR1 2DH