Regulation 28: Prevention of Future Deaths report

Gary OTTWAY (died 01.04.21)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Chief Executive Officer** **East London NHS Foundation Trust** **Trust Headquarters** **9 Alie Street** **London E1 8DE**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 7 April 2021 I commenced an investigation into the death of Gary Ottway aged 41 years. The investigation concluded at the end of the inquest on 11 March 2022. I made a determination at inquest that Gary Ottway died from natural causes, being two heart conditions. His medical cause of death was: 1a acute left ventricular failure 1b valvular heart disease with significant cardiomegaly and coronary artery disease.
4	**CIRCUMSTANCES OF THE DEATH**

	Death was triggered by the psychological stress and physical exertion of a severe mental health episode. Mr Ottway had been admitted to Mile End Hospital and detained under section 2 of the Mental Health Act, and at the time of his death was being detained alone in a seclusion room where he was under constant / continuous nursing observation. Nevertheless, he was found in cardiac arrest, cold and with post mortem staining (hypostasis).
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. Though Mr Ottway was meant to be under constant nursing observation, not only was he in cardiac arrest but he was also cold and exhibiting hypostasis when he was found. This appears to indicate that either the nursing observation was not constant, or it was not effective. I appreciate that the trust is putting in place a new IT system to monitor signs of life, but nevertheless basic nursing observations must be performed competently. When the senior duty nurse and the nurse undertaking continuous observation noted that they could not see evidence of respiration, they did not immediately enter the seclusion room where Mr Ottway lay, because they deemed that unsafe following his earlier violent behaviour. 2. The senior duty nurse told me at inquest that he could not be sure that Mr Ottway was not holding his breath, though he had never done this and there was no evidence that he was doing so now. 3. The senior duty nurse also told me that the visibility through the Perspex panel was poor, though he had never brought this to anyone's attention and did not do so after Mr Ottway's death. 4. The senior duty nurse told me that the nurses would not enter the seclusion room until the rapid response team was present, but he did not call the rapid response team as soon as he suspected that Mr Ottway was not breathing. Instead, he started by going to get one of the other nurses, which took a couple of minutes; then he rang the duty doctor; and only after that did he radio for the rapid response team.

	5. The junior doctor was the last person to attend the resuscitation and told me he did so after the rapid response team, yet no one had entered the seclusion room by the time he arrived. It may be that there was a (perhaps unconscious) reluctance to enter the room without a doctor, despite the presence of the rapid response (nursing) team. But by the time the junior doctor got to the door and immediately identified that Mr Ottway was not breathing, at least six and a half to seven minutes had elapsed since the first two nurses saw no evidence of respiration. This was well outside the three to four minute window of opportunity for resuscitation without inevitable brain damage or death. 6. In the six and a half to seven minutes before the junior doctor arrived at the seclusion room, the emergency grab bag had not. That took another 30 seconds, though to retrieve it was only a three minute round trip from the room where the nurses who had first identified the lack of respiration were waiting. 7. The junior (and only) doctor called to assist in the attempted resuscitation was not familiar with the contents of the emergency grab bag, told me that it would not have occurred to him to ask for any equipment to assist with ventilations other than a pocket mask, and explained that he was not trained in giving adrenaline or any other medicines for resuscitation. As he was the only medical resource available in the case of an emergency, these seem significant gaps. 8. When paramedics arrived, they found that chest compressions were being given (by nursing staff) to Mr Ottway's abdomen instead of his chest, thus rendering them ineffective.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 16 May 2022. 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 following. • [redacted], Gary Ottway's father and sister • Care Quality Commission for England • HHJ Thomas Teague QC, the Chief Coroner of England & Wales 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	**DATE** **SIGNED BY SENIOR CORONER** 18.03.22 *ME Hassell*