MR G IRVINE
HIS MAJESTY'S SENIOR CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: 13715321

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], **Chief Executive, ELFT , 9 Alie Street, E1 8DE** [redacted] 2. **The Rt Hon Thérèse Coffey MP, The Secretary of State for Health and Social Care, 39 Victoria St, Westminster, London SW1H 0EU** [redacted]
1	**CORONER** I am Graeme Irvine, acting senior coroner, for the coroner area of East 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. 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 7th May 2021 I commenced an investigation into the death of Delina Etienne, age 76 years. The investigation concluded at the end of the inquest on 7th & 8th September 2022. I made a determination of a short form conclusion of death from natural causes. The medical cause of death was determined following a post-mortem examination; *1a Ischaemic Heart Disease* *1b Coronary Artery Atherosclerosis*

4	**CIRCUMSTANCES OF THE DEATH** Mrs Etienne had suffered from schizo-affective disorder since the mid 1980s and had been treated in the community and in hospital with psychotropic medications to manage her symptoms. In late 2020 Mrs Etienne suffered a relapse of psychosis and was voluntarily admitted to a mental health ward for treatment. After a period of stabilisation Mrs Etienne was discharged home but returned shortly thereafter when symptoms returned in April 2021. Happily, she seemed to respond to treatment and plans were made for discharge on 8th May 2021. At 06.00 hrs on the morning of 7th May 2021 Mrs Etienne was observed to be asleep in her bed. At 06.24 hrs when a set of clinical observations were to be taken from the patient, Mrs Etienne was found to be unresponsive by the senior staff nurse on duty. The nurse shouted for assistance but did not follow the expected policy for these circumstances, he did not commence proper checks of the patient or initiate CPR. Another nurse on duty did commence chest compressions whilst the senior staff nurse went to collect emergency equipment. The senior nurse returned with the emergency bag but critically did not extract equipment from the bag or initiate the use of a defibrillator. The senior nurse left the scene a second time to establish whether Mrs Etienne was subject to a do not attempt resuscitation order (DNACPR). Such orders are stored in a red folder placed prominently in the ward nurse's station. The senior nurse ignore that file and instead opened the patient's electronic medical records and arrived at the erroneous view that Mrs Etienne had a DNACPR in place. He returned to Mrs Etienne's room and advised his colleague to stop resuscitation. Mrs Etienne was declared deceased at the scene. The actions of the senior nurse were **not** found to have caused or contributed to Mrs Etienne's death, based on relevant expert opinion.
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. The response of the nursing team to a cardiac arrest was chaotic, and failed to follow trust and national guidelines designed to maximise the effectiveness of resuscitation. 2. Whilst Mrs Etienne was an inpatient, the ward failed to escalate episodes of raised blood pressure for medical review in contravention of trust policy. 3. At no time during the two periods of Mrs Etienne's inpatient care was she assessed for venous thromboembolism (VTE) risk in contravention of trust policy. 4. An episode of chest pain identified by nursing staff on 21st April 2021 was escalated for medical review, no evidence of such a review exists. 5. When nursing staff discovered that they had fallen into error by asserting that Mrs Etienne had a DNACPR in place the matter was discussed with ward management on the morning of 7th May 2022. Despite that, the error was not admitted; A. To officers of the Metropolitan Police who investigated the circumstances of the death that morning,

	B. To the Trust's governance team – an incident report (DATIX) failed to mention the error, C. To Mrs Etienne's family who, subject to the Trust's statutory "Duty of Candour" were communicated with by telephone and in person on 7th May 2021 and in written correspondence on 10th May 2021
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 **8th November 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 Chief Coroner and to the following Interested the family of Mrs Etienne, the Care Quality Commission, the Nursing and Midwifery Council, the Metropolitan Police Service and to the local Director of Public Health who may find it 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	**[DATE]** 12/9/22 **[SIGNED BY CORONER]**