REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Chief Executive, St George's University Hospital NHS Foundation Trust, St George's Hospital, Blackshaw Road, London. SW17 0QT [redacted] The Roehampton Surgery, 191 Roehampton Lane, London. SW15 4HN. Chief Executive, NHS South West London Integrated Care Board, First Floor 73-75 Upper Richmond Road, London. SW15 2SR
1	**CORONER** I am Professor Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West 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.
3	**INVESTIGATION and INQUEST** On the 24th, 25th and 26th April 2023 evidence was heard touching the death of Mrs Elsie Leaver. She had died on 23rd August 2020, aged 89 years. **Medical Cause of Death** 1 (a) Multiple organ failure (b) Mixed drug overdose 11 Depressive illness, chronic obstructive pulmonary disease, Ischaemic heart disease, Hypertension, Frailty.

	How, when, where the deceased came by her death: Mrs Leaver was admitted to St George's Hospital, (SGH) on 15th August 2020 suffering with phenytoin toxicity. She had an extensive psychiatric history recently complicated by overdose and suicidality. This was not recognised by the clinical team despite evidence available in the electronic records, concerns raised by the family and intermittent agitation. She was deemed to have reduced mental capacity between 16th August 2020 and her discharge for rehabilitation to Queen Mary's Hospital (QMH) on 18th August 2020, but her bag was not searched. [redacted] On transfer to QMH, she was found to have capacity and again refused a bag search. Overnight on 19th August 2020, she expressed suicidality to her family who notified nursing staff at QMH. On 20th August 2020, this suicidality was explored by the SHO who found her not to be actively suicidal and sought no advice from the psychiatric liaison service. On 22nd August 2020, whilst collateral psychiatric history was being sought after she threatened self-discharge, at approximately 15:00 she took an overdose [redacted] Mrs Leaver was readmitted to SGH and died there on ITU at 16:37 23rd August 2020 as a result of the overdose. The failures in care and communication together constitute a "total picture" that amounts to neglect. **Conclusion of the Coroner as to the death:** Mrs Leaver took her own life whilst suffering from depressive illness. Her death was contributed to by neglect.
4	**Circumstances of the death.** Extensive evidence was taken and accepted by the court. In summary, of relevance to this report: On 14th August 2020 Mrs Leaver attended SGH with 3 odd episodes though to be due to a TIA and discharged on aspirin. She re-attended with a history of a fit with a past history of epilepsy on phenytoin on 15th August 2020 and was admitted to SGH under the medical team. The neurologist thought it likely that her phenytoin would be low and when it was found to be in the toxic range ascribed the fit to phenytoin toxicity and she was admitted for monitoring, stopping phenytoin, and restarting once levels back to normal. No active consideration was given as to the possible cause of this toxicity, which could have been due to overdose, given her psychiatric history as outlined below. Despite being under active psychiatric care from the CMHT for older persons, being on psychiatric medication, taking a call from the CMHT whilst an inpatient at SGH, having taken an overdose in November 2019, having multiple hospital attendances, including 17th July 2020 with suicidal ideation to Kingston, suffering agitation, concerns being raised about her mental health by her family, a safeguarding concern being raised against her partner/friend, and intermittent agitation requiring diazepam, 1:1 nursing, the attendance of her son and hospital security and presenting with drug toxicity, psychiatric illness was never considered. She was seen by multiple clinicians at SGH, none of whom undertook any psychiatric history, or made any proper inquiry with her relatives, nor of her electronic notes.

This deprived her of a holistic assessment. There was no referral to psychiatric liaison services, nor advice sought from them at either site.

Mrs Leaver therefore did not have a self-harm risk assessment despite her presentation and past history, which would have likely prompted more active searching of her belongings for medication which could be potentially used in an overdose. This could have been undertaken even against her permission when she had reduced capacity in her best interests.

Mrs Leaver had declined a bag search on admission to the ward at SGH which was apparently passed on verbally to the day team. This did not appear to have been acted upon and was not recorded, such that a search never occurred.

This was compounded by the fact that when psychiatric illness was finally being considered at QMH from 20th August 2020, there was only an informal telephone advice available, the quality of which varied with the person who took the call, and anything further required the transfer of Mrs Leaver back to SGH by LAS to A&E.

I understand that the NHS South West London Integrated Care Board declined to provide formal psychiatric cover to QMH, neither formal telephone advise nor staff on site to see patients.

In evidence this was identified as a lacuna in the service provision at QMH, by all the clinicians with whom it was discussed, such that for the last 10 years psychiatric liaison has been providing informal telephone advice without the need for the patient to be transferred back to A&E at SGH.

The Health Information Exchange viewer, (HIE) available to doctors with in St Georges Hospital Trust at the time, contained a GP summary which did not contain the recent overdose or CMHT treatment as part of the active problem summary, nor even depression as a diagnosis despite a relapsing and remitting history of depression and anxiety going back to 2006.

HIE did contain sections of her RIO notes (psychiatric records) which appear to have been missed and details of attendence with suicidal ideation at Kingston 19th July 2020, which also appears to have been missed or disregarded by the clinicians.

Senior doctors in evidence were not aware of the information on the HIE.

Instead the incomplete past medical history which listed anxiety and dementia appears to have taken at face value.

As above, severe agitation at SGH did not prompt a reconsideration, neither did tearfulness and low mood at QMH.

Concerned phone calls from family were not logged nor passed to clinicians until she expressed active suicidality, and no doctor returned a call to the family until the daughter insisted on the 22nd August 2020 that if no doctor called her back to discuss her concerns about her mother she would attend the hospital despite the pandemic.
By then it was all too late.

The lack of psychiatric history taking deprived Mrs Leaver of the opportunity for psychiatric liaison opinion and risk assessment that would have been likely to have discovered medication she had secreted in her bag that she subsequently consumed to lethal effect.

This was despite the fact that for at least 2 out of the three days that she was at SGH from 15th to 18th August 2020, she was found by nursing staff to lack full mental capacity.

	I understand that considerable training has now been given on this issue so that patients who lack capacity may have their belongings searched to identify and secure dangerous items such as medication. There were also concerns that her suicidality may have been exacerbated by drug interactions between phenytoin and diazepam. These matters have been addressed by SGH in the training of its clinicians.
5	**Matters of Concern** 1. That the GP summary did not contain pertinent psychiatric history that would have assisted the hospital clinicians to identify Mrs Leaver's depression and specifically her suicidality. 2. That doctors at SGH do not take a reasonable psychiatric history as part of their clerking and thus fail to make a proper holistic assessment of the patient and potentially miss the opportunity to manage risks such as those in this case which may lead to death. 3. That doctors at SGH need training on the information available on HIE and how to access it. 4. That NHS South West London Integrated Care Board has made no formal provision for psychiatric liaison cover at QMH, despite there being such a clear clinical need for this that the team from psychiatric liaison have felt compelled to provide informal telephone advice for the last 10 years. 5. That the lack of formal psychiatric advice availability at QMH puts vulnerable patients at increased risk, since the only way to properly access such advice is for them to be sent by LAS ambulance to A&E at SGH, when they are physically frail, given that QMH is a rehabilitation unit.
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. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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], children of the Mrs Leaver, by email. [redacted] Clinical Director, Springfield Hospital, 61, Glenburnie Road,

	London. 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	**26th April 2023.**  **Professor Fiona J Wilcox** **HM Senior Coroner Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED** **Inner West London Coroner's Court,** **33, Tachbrook Street,** **London.** **SW1V 2JR** **Telephone:0207 641 8789.**