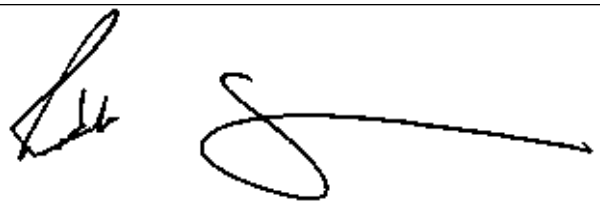
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted]; CEO Hampshire Hospitals NHS FoundationTrust** **2 [redacted]; CEO Southern Health NHS Foundation Trust**
1	**CORONER** I am Robert SIMPSON, Assistant Coroner for the coroner area of Hampshire, Portsmouth and Southampton
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 08 July 2021 I commenced an investigation into the death of Sebastian Harry DANIELS aged 26. The investigation concluded at the end of the inquest on 01 September 2023. The conclusion of the inquest was that: On the 4th July 2021 Sebastian Harry Daniels died at the Royal Hampshire County Hospital in Winchester. He died as a result of a hypertriglyceridemia caused by his diabetes, obesity and medication that he required to control his enduring mental health condition. This condition was identified during a blood test on the 30th April 2021 but the result was passed on in a manner which did not trigger a medical review.
4	**CIRCUMSTANCES OF THE DEATH** Mr Daniels suffered from paranoid schizophrenia and was prescribed clozapine in early 2019. This was effective in controlling his mental health difficulties. Patients taking clozapine require close monitoring of their physical health due to the risks associated with the medication and attend a 4-weekly clinic. Blood samples are taken at these clinics to monitor white blood cell counts. In addition to the regular clozapine clinic Mr Daniels underwent a periodic physical health check in accordance with the relevant guidelines and Southern Health policy. At the check on the 1/4/21 a blood lipid profile (including triglycerides) was not requested as it should have been. The multi-agency Root Cause Analysis (RCA) report identified this as a missed opportunity to monitor Mr Daniel's blood lipid levels. On the 30/4/21 Mr Daniels attended Basingstoke & North Hampshire Hospital ED due to abdominal pain. Blood tests were requested but Mr Daniel's self-discharged prior to the results becoming available. Owing to the appearance of the blood sample the testing technician added triglyceride levels to the test results. These were abnormal and significantly raised. The ED doctor preparing the discharge summary included the blood test results but did not flag the triglyceride levels as abnormal or requiring attention by Mr Daniel's GP. As a consequence, the GP surgery administrative staff filed the discharge note without bringing it to the GP's attention. Subsequent blood tests reported on the 29/6/21 revealed even higher levels of triglycerides. The GP was concerned about the levels given this leads to a risk of

	pancreatitis and took steps to commence treatment. On the 3/7/21 Mr Daniels was taken to hospital by ambulance with abdominal pain. Despite treatment his health deteriorated quickly and he sadly died on the 4/7/21. The medical cause of death was recorded as: 1a Multiple Organ Failure 1b Severe necrotising pancreatitis 1c Severe hypertriglyceridemia due to clozapine therapy, diabetes mellitus and obesity II Hypertensive Heart Disease and paranoid schizophrenia
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) 1 The abnormal triglyceride levels in Mr Daniel's blood, whilst reported by the lab, were not escalated by telephone as this was not required by the hospital procedure at the time. I am pleased to note that Hampshire Hospitals Trust have updated their procedures to include telephone escalation of raised triglyceride levels. However the RCA report indicated that the findings in this case should be shared with the Royal College of Pathologists with a request that raised triglyceride levels be added to the RCPath guidelines for telephone action. In information received after the inquest the Hampshire Hospitals Trust advised that they could not tell me whether or not this action has been undertaken. 2. The RCA report identifed that the format of discharge summaries provided to GPs by the ED department needed to be reviewed to ensure that actions to be undertaken by GPs were clearly identified. The results of this were to be audited. Following the inquest I was provided with an audit report. This report dated 13/9/21 revealed that the computer system could not be altered as had been hoped and therefore a change of practice was introduced instead. This required clinicians to document actions in a free text section with appropriate flagging for GPs. 20 cases were audited and only half met the standardised national guidance and 8 lacked a clear diagnosis & details of what was expected from GPs. Hamsphire Hospital Trust have informed me that further actions are being taken to address these deficiencies. However as it is now a year since the RCA report was prepared and over 2 years since Mr Daniel's death I am concerned that this action is not being taken swiftly given the risks to patients. 3. In relation to the blood tests required under the clozapine guidelines I was informed that Southern Health take the monthly blood tests and run these in the clozapine clinic. However the blood tests required of the annual physical health checks are not taken by the Southern Health staff but rather patients are required to attend phlebotomy services elsewhere for the blood to be taken. I heard evidence during the inquest that Mr Daniels had missed some of these blood test appointments which meant his full tests were not carried out when expected. Clozapine is prescribed only to patients suffering from an enduring mental health condition for whom other medication has not been effective which indicates that they may be at risk of having difficulty managing appointments.

	I heard evidence from the consultant psychiatrist responsible for Mr Daniel's treatment that they were not permitted to take the blood samples and submit them to the local laboratory for testing. I was informed that the Southern Health staff had requested to be able to do this to avoid the patient having to attend another appointment. I have reviewed further information provided after the inquest by the Clinical Director of Southern Health. She has explained that they lack the facilities to complete the full blood tests and they lack the resources to take and deliver samples to the laboratories; noting that no community mental health teams in their trust routinely provide phlebotomy services. She has advised that they are focussed on better communication with primary care and assertive outreach where necessary. I remain concerned that patients on high risk medication, who by the nature of their mental health condition may struggle to attend appointments, are required to arrange or attend separate blood tests. I note that clozapine clinic staff take blood monthly and that the phsyical health reviews are carried out by doctors all of whom should be capable of taking a blood sample for submission to a laboratory.
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 November 17, 2023. 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] I have also sent it to **Royal College of Pathologists** 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 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 by the Chief Coroner.
9	**Dated: 22/09/2023**

	 **Robert SIMPSON** **Assistant Coroner for** **Hampshire, Portsmouth and Southampton**