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 Chief Executive, Nottinghamshire Healthcare NHS Foundation Trust**
1	**CORONER** I am Miss Laurinda Bower, HM Area Coroner, for the coroner area of Nottingham City and Nottinghamshire
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 05 January 2022, I commenced an investigation into the death of Michelle Louise WHITEHEAD, aged 45. The investigation concluded at the end of an inquest, conducted before a Jury, on 21 September 2023. The conclusion of the jury was as follows: Michelle Louise Whitehead died on Friday 7 May 2021, while an inpatient on the Adult Intensive Care Unit, Kingsmill Hospital, Sutton-in-Ashfield, Nottinghamshire. Her death came as a result of Hyponatraemic Encephalopathy, caused by Acute Hyponatraemia, caused by Psychogenic Polydipsia. Failings in her care probably more than minimally contributed to her death.
4	**CIRCUMSTANCES OF THE DEATH** Michelle had been detained pursuant to s.2 of the Mental Health Act 1983 on Monday 3 May 2021, and was taken to the Lucy Wade Unit, Millbrook Hospital. Her detention was necessary because there had been a serious deterioration in her mental health in the days prior. Michelle was displaying symptoms of paranoia, irritability, agitation and reality distortion. In the days following her admission to hospital, she appeared to be experiencing psychotic symptoms and lacked the capacity to make decisions about her health and wellbeing. There was a single observation by a staff nurse of Michelle excessively consuming water from the tap in her en-suite bathroom at around 15.48 hours on 5 May 2021. As Michelle was nursed on 10-minute observations, and had unsupervised access to water in her room, it is not possible to know how much water she actually consumed or over what period. After this episode of water consumption, she was administered PRN sedative medication, which took effect by 17.30 hours when she became compliant and got into bed. Over the course of the next 3 hours, Michelle was assumed by staff to be sleeping. Staff failed to follow the Trust's Rapid Tranquilisation policy as; • The Rapid Tranquilisation NEWS2 observations were incomplete as Michelle's consciousness level was not assessed at any time before concerns were raised about her breathing and shortly before 21:00 hours. This led to missed opportunities to

	detect her likely deteriorating level of consciousness, and to have sought earlier hospital admission. • Medical and non-clinical staff did not understand the requirements of the Policy in circumstances where a patient is thought to be asleep. • NEWS2 observations were discontinued by a doctor at 19:45 hours despite the policy mandating hourly observations, direct visual observation of the respiratory rate every 15 minutes, and continuous pulse oximetry monitoring until the patient is ambulatory. • There was inadequate monitoring of Michelle by staff tasked with performing 2:1 eyesight observations, as staff were distracted by the use of their personal mobile telephones, an activity which was prohibited on the ward. • There was a failure by nursing staff to respond promptly to a change in Michelle's breathing at 20:28 hours, and a delay of 15 minutes in Michelle being placed into the recovery position • There was a delay in the Duty Doctor arriving on scene as he did not respond promptly to mobile telephone contact from the switchboard. • There was a 10-minute delay in admitting the paramedics to the building On a balance of probabilities, Michelle suffered a fatal brain injury caused by acute over-hydration of water leading to severely low sodium levels. In this context, the acute over hydration was caused by Psychogenic Polydipsia, a feature of Michelle's mental ill health which had not been diagnosed. The Trust's admitted failure to comply with its Rapid Tranquilisation policy on the evening of 5 May 2021 – in particular by failing to monitor Michelle's consciousness level, lead to missed opportunities to detect her likely deteriorating level of consciousness and to seek earlier hospital admission – probably more than minimally contributed to her death. The Trust's system for training staff on the Rapid Tranquilisation policy was not sufficiently robust, and the policy itself was not sufficiently clear on what staff ought to do if they believe a patient to be asleep after administering tranquilisation.
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) **Nottinghamshire Healthcare NHS Foundation Trust** 1. The Trust's Rapid Tranquilisation policy has not been sufficiently embedded through learning and development to ensure that all staff have a good working knowledge of the requirements for safely monitoring patients following the use of sedative medications I heard evidence that ward staff had all received training on the policy as part of their initial induction, but all staff in this case had consistently failed to follow the policy, including senior ward leaders and medical staff, who informed the court that they were simply not aware of the necessary safeguards to monitor a patient's consciousness level after administering tranquilisation medications, or how to do so when the patient was thought to be sleeping.

	2. The Trust's Rapid Tranquilisation policy is not sufficiently clear on what action should be taken if a patient is considered to be unconscious during the period of monitoring, or is felt to be asleep. The current iteration of the policy (revised after Michelle's death) does not make it clear that any suspected *unconsciousness* should result in the immediate summoning of a doctor and alerting the ambulance service via 999. Further, the revised policy does not make it clear which vital sign observations should be undertaken and recorded if a patient is thought to be asleep in the period post rapidly tranquilisation and until the patient is ambulatory. This is despite the policy listing reduced consciousness and respiratory depression as known risks of sedative use, which can lead to death. 3. The Trust's current policy appears to depart from National guidance – NICE issued Rapid Tranquilisation Guidance in Notice NG10 in May 2015 The Trust advised me in the course of the inquest that their policy *was* in line with other local mental health Trusts. However, a review of NICE guidance and other Mental Health Trust policies, available via a brief internet search, demonstrates differences in the advised monitoring protocols. I have shared with the Trust both the NICE guideline and a copy of the publicly available policy issued by a London Trust in February 2022 for comparison. The Trust should take urgent action to ensure their guidance is in line with National guidance, or where it departs, ensure there is sound clinical reason for doing so. 4. Psychogenic Polydipsia – there appears to be no guidance, either locally or nationally, on the management of this condition, despite the research literature demonstrating that 50% of reported cases of over-hydration appear to be linked to psychosis. The Mental Health Commission for Scotland issued a report on the final day of Michelle's inquest, related to the death of another mental health patient, Mr D, making recommendations for all NHS bodies to ensure staff have information to detect and manage acute physical health scenarios including polydipsia and water intoxication. The Trust should take urgent action to ensure their staff are able to detect and manage this rare but potentially fatal condition. I shall include the Department for Health and Social Care, NHS England, NICE and the Royal College of Psychiatrists as recipients of this report, for information sharing purposes, as it may inform future discussion about the management of two important but separate features of metal health care that each carry a risk of death, namely, (a) the use of Rapid Tranquilisation and (b) the detection and management of Psychogenic Polydipsia.
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 29, 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; • The Interested Persons • The Department for Health and Social Care • NHS England • NICE • The Royal College of Psychiatrists 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: 4 October 2023** **Miss Laurinda Bower** **HM Area Coroner**  **Nottingham City and Nottinghamshire**