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 of 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 06 June 2019 I commenced an investigation into the death of Christopher Howard SMITH. The investigation concluded at the end of an Article 2 compliant inquest, conducted before a jury, between 12 December 2022 and 19 January 2023. The conclusion of the jury was that: Christopher Howard Smith, was a 35-year-old gentleman who was a serving prisoner at HMP Lowdham Grange, Nottinghamshire. Christopher died on the 19th of May 2019, at Queen's Medical Centre, Nottingham, from a cardiac arrest, due to a massive Pulmonary Embolism, predisposed by Deep Vein Thrombosis. In spite of prolonged efforts to resuscitate him, Christopher passed away. He had a severe and enduring Mental Health condition known as Schizo-affective disorder which was controlled with anti-psychotic medication (Promethazine and Olanzapine). The jury found multiple failings in the care and treatment provided by prison and healthcare staff. His death was contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** The jury reached the following findings of fact – On the 23rd April 2019, Christopher was transferred to the segregation unit (known as the RIU). He was seen and recorded to be behaving strangely from the 1st of May and was recorded in the observation log by a PCO as being "off his head". A variety of staff from the 1st of May onwards, thought his presentation was due to him being under the influence of an NPS. This unusual behaviour included smashing up his cell, not engaging in the daily regime or with staff, and shadow boxing. His condition deteriorated over the course of the following days since the cessation of his mental health medication on the 1st of May. His presentation included an inability to communicate, drooling, vomiting, difficulty breathing, jerking of his limbs and inability to mobilise. This progressive deterioration was noted by both prison and healthcare staff over the following days up to the 8th May when Christopher was hospitalised. Christopher was also not eating or drinking adequately, and concerns were raised in this regard as of the 3rd of May. There were insufficient checks and inadequate record keeping by prison staff and the concerns that Christopher's presentation raised were not thoroughly escalated through the correct channels between the 1st and the 6th of May.

Prison officers were reluctant to challenge Healthcare staff regarding the lack of clinical assessments being carried out.

His progressive deterioration was recorded by both prison and healthcare staff in their respective logs and in spite of this and in spite of the stipulations of rule 45 and PSO 1700, his assessments were inadequate, and his healthcare needs were not met. His failure to take his medication was not adequately assessed nor was his mental capacity questioned. The food and fluid log was not opened until the 7th May and an NPS not opened until the 6th of May. Consequently, there were significant missed opportunities to help Christopher. A NEWS2 score was not calculated until the 8th of May, as which point it was 8.
Healthcare staff were not refused or prevented from entering Christopher's cell, although there were occasions of reluctance from prison staff to open the cell door due his presentation and behaviour. Healthcare staff had adopted the unsafe practice of conducting clinical observations through the observation hatch.

On the 6th of May, Christopher was moved from his cell for hygiene reasons and to facilitate observations via CCTV. An NPS log was opened on that day for the first time but opportunities to examine him were missed. Further opportunities were missed on the 7th of May, when a food and fluid log was opened. There was confusion between physical and mental healthcare staff as to who was responsible for assessing Christopher's health condition and providing appropriate care. There was insufficient communication between healthcare departments which was exacerbated by chronic understaffing.

On the 8th of May, the GP round was inadequate being conducted quickly through the observation hatch. Once again, opportunities for appropriate clinical observations were missed.

Clinical observations were eventually made by nursing staff for the first time shortly after 1PM on the 8th of May 2019, but there was further significant delay before the ambulance was called via contacting 999 and a code blue was not called at this time.

The 999 call was made at 1:57pm but inaccurate and insufficient information was conveyed to the call centre. A further assumption was made that Christopher was displaying symptoms due to exposure to spice.

On arrival at QMC accident and emergency department, there was no written handover given to hospital staff as per healthcare policy.

On admission, Christopher was very unwell, and hospital staff took the decision to sedate him and put him on artificial ventilation, in order that they could investigate him further. He was rehydrated and was given prophylactic treatment for DVT. There are conflicting accounts as to whether Christopher had swollen foot or feet, but this was not conveyed to the medics at QMC. Based on the fact that a fellow prisoner on RIU and prison staff at Lowdham Grange witnessed Christopher having a swollen foot or feet, we believe that on the balance of probability, Christopher did have swelling of his foot or feet.

Christopher remained on ventilation for 5 days, after which there was an improvement in his condition, but he remained unwell. He was subsequently transferred to the neurology ward on the 17th of May and a diagnosis of probable Neuroleptic Malignant Syndrome was made. This diagnosis was not considered by healthcare staff at HMP Lowdham Grange.

The probable cause of NMS could not be firmly determined based on a lack of clear understanding of the condition, which is rare. We are unable to say whether the condition was caused by either the taking or the cessation of anti-psychotic medication.

Christopher's extended immobility in his cell resulting from NMS, in combination with his dehydration, predisposed him to the development of DVT which ultimately lead to his death due to Pulmonary Embolism.

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) The accounts detailing Christopher's decline over the course of a week; from a young, fit, engaging and polite gentleman, to a man who could not speak, eat, or properly stand, were harrowing for all to hear, not least his family. These accounts were supported by CCTV footage demonstrating Christopher's extreme vulnerability on account of his acute ill health. I remain unable to comprehend how, in the face of Christopher's clear need for urgent medical assistance, this was not facilitated for him by those charged with the responsibility for his care, at a time when Christopher was unable through illness to ask for help. This was a clear case of the most serious neglect contributing to Christopher' tragic death. **1. An inability to provide prisoners at HMP Lowdham Grange with safe clinical care** I heard evidence, and the jury reached findings, that there was an unsafe practice of staff conducting important healthcare and wellbeing observations via the cell door observation hatch. Observing an unwell prisoner through a hatch slightly larger than a letterbox undermines the safety of the clinical assessment. Healthcare staff did not utilise the NEWS2 system of monitoring the condition of an acutely unwell prisoner, despite the Trust having adopted this recognised healthcare tool many years prior. The Forensic Directorate has continued to lag behind other areas of the Trust where NEWS2 is fully embedded and this has previously been identified as an issue linked to other deaths. There was a lack of robust GP visits, despite such being mandated by the Prison Rules. When visits did take place, they were often via the cell door observation hatch and conducted as "fleeting glances" rather than robust clinical assessments. Again, this is unsafe. There was a lack of effective leadership of the healthcare department to ensure that staff had created a safe plan of care for Christopher. Senior personnel were not aware of Christopher's week-long deterioration in the segregation unit until very late in the chronology of events, nor were they aware of a dispute between the mental health and physical health teams as to the differential diagnoses that might be causing his concerning symptoms and deterioration. Despite daily lunch time meetings, there was a stark lack of professional curiosity from senior staff as to the plan of care for Christopher and what safety netting, if any, was in place. **2. An inability to record, retain and supply HM Coroner with material relevant to the inquest** The progress of this inquest, taking places years after Christopher's death, was halted many times due to the late disclosure of material relevant to the inquest. Policies and procedures said to exist at the time were produced mid-hearing. Despite the Trust having conducted their own review of the case, being provided with ample notice of the inquest hearing, and having attended multiple pre-inquest review hearings, there was an inability to identify key material and to supply that to the court in good time. The ability to reflect on the care provided in advance of a prisoner's death is dependant on the Trust's ability to isolate the relevant evidence, and to analyse it. Without the appropriate professional curiosity to understand exactly what happened, the Trust will repeatedly miss opportunities to learn from deaths and to take action to seek to prevent future deaths.

	An example of this, is the issue of a lack of safe system for NEWS2 monitoring of acutely unwell patients. This issue has repeatedly been raised at inquests involving the Trust's forensic division. **3. A complete lack of candour, openness and honesty when engaging in post death investigations.** Without exception, each witness from the healthcare trust accepted some level of failing in the care they provided to Christopher. Yet none of the witness statements submitted in advance of the inquest contained any such reflection of what went wrong or what should have happened. Despite a Direction from the court that the Head of Healthcare was to submit a statement "nailing colours to the mast" as to what the genuine issues of care were i.e. what policies were in place at the material time and whether care had departed from those policies, a candid statement satisfying this Direction was not forthcoming. This left the Coroner and the other Interested Persons, especially Christopher's family, at a distinct disadvantage in identifying the actual issues, because of an overwhelming unwillingness to act in an open and honest manner, contrary to the expectations of a state agency when engaging in an inquest. If staff are either unwilling, or are not given the opportunity, to reflect on what went wrong in an open and honest manner, then the Trust cannot seek to learn from events at the earliest opportunity, and these issues of concern will persist, leading to further deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 September 26, 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 Interested Persons including: **Christopher's family** **The Governor of HMP Lowdham Grange** **HMPPS – The Minister for Prisons and Probation** **CQC** I have also sent a copy to **NHS England** (who commission prison healthcare services) and to **Sodexo** – Sodexo did not manage the prison at the time of Christopher's death, but have subsequently taken over management of the prison from Serco and I consider it important that they are aware of these historic issues. 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: 7 July 2023** **Miss Laurinda Bower** **HM Area Coroner for** **Nottingham City and Nottinghamshire**