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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO: St Andrew's Healthcare, Birmingham** |
| 1 | **CORONER**<br><br>I am Emma Brown, HM Area Coroner for Birmingham and Solihull |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 2 May 2023 I commenced an investigation into the death of Sasha Honey MISHABI. The investigation concluded at the end of the inquest . The conclusion of the inquest was; Natural causes. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Mr Mishabi died at the Queen Elizabeth Hospital Birmingham on the 18th April 2023. He was a detained mental health patient under section 37/41 of the Mental Health Act at Lifford Ward, St Andrew's Healthcare ('SAH'), Birmingham for the treatment of personality disorders and schizoaffective disorder of a severe and enduring nature. Mr. Mishabi's physical health was also poor due to diabetes mellitus type 2, essential hypertension, end stage renal failure and heart failure, he also had poor nutrition and generally used a wheelchair. Mr. Mishabi's personal hygiene was poor and due to his mental health condition he would often refuse assistance despite suffering episodes of incontinence. He had developed painful skin ulcers to his buttocks that were first identified at SAH on the 15th March 2023 and initially thought to be pressure sores. Dressings were applied.<br><br>Mr. Mishabi was admitted to the Queen Elizabeth Hospital on the 17th March 2023 for management of urinary retention. He was found to have a urinary tract infection and anaemia. He was treated and clinically stable when discharged back to SAH on the 2nd April 2023. On admission it was also identified that he had grade 2 ulcers to his left buttock that were thought to be pressure related and was managed accordingly.<br><br>Following discharge the ulcers proved difficult to manage and deteriorated. Therefore Mr. Mishabi was admitted to the Queen Elizabeth Hospital on the 6th April 2023 for input from the tissue viability team at which time signs of local infection were identified which were treated with antibiotics. He was reviewed by a tissue viability specialist on the 12th April 2023 who felt that the ulcers were not pressure ulcers. Consequently on the 14th April he underwent a surgical review, a pelvis CT with contrast and a dermatology opinion was obtained to consider what the nature of the ulcers was and how they should be managed. No abcesses or collections were identified and the appropriate management was advised to be ongoing antibiotics. Mr. Mishabi continued to be clinically stable with all observations within normal limites until the 16th April 2023 when he had an episode of pyrexia and tachycardia during the morning prompting investigations. The only other cause for concern on the 16th was a low blood sugar during the early evening but this responded to treatment. However at 22:35 on the 16th April 2023 Mr. Mishabi suddenly became unrousable and suffered a cardiac arrest. He was successfully resuscitated but subsequently developed an overwhelming bronchopneumonia which despite treatment lead to his death.<br><br>Based on evidence heard at the inquest from a variety of clinicians and [redacted], pathologist, the medical cause of death was determined to be:<br><br>**1a Bronchopneumonia** |

**1b Cardiac Arrest**

**1c Local infection of unknown origin with diabetes mellitus; hypertension; end stage kidney failure; ischaemic heart disease and heart failure**

**II Skin infection of the buttocks with superficial ulceration**

The skin ulcers were determined not to be pressure related and at post mortem were seen to be healing and uninfected, therefore it was concluded that they did not play a significant part in Mr. Mishabi's death.

However, the inquest did examine the pressure area risk assessments, prevention management and ulcer care at the University Hospitals of Birmingham and St. Andrew's Healthcare.

**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 will 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. Awareness of and compliance with St. Andrew's Healthcare 'Pressure Ulcer Prevention and Management ' Policy Due to his chronic physical health conditions Mr. Mishabi was at very high risk (score of 21) of pressure damage and ought to have had weekly waterlow assessments and daily skin inspections with more frequent assessment and inspection to be considered in the event of change such as the development of an ulcer. Statements were provided from [redacted], Consultant Psychiatrist, and [redacted], Lifford Ward Manager, on behalf of SAH in advance of the inquest. The statements included information on Mr. Mishabi's waterlow assessment and skin inspections, and provided some records. At no time was it identified that the SAH 'Pressure Ulcer Prevention and Management Policy' was not followed in Mr. Mishabi's case. At inquest it was identified that [redacted] had forgotten that there was such a policy (he initially denied there was a policy/procedure for waterlow assessments and later, after the policy had been produced, said there was but he had forgotten about it). The areas of non compliance identified at inquest were as follows:
    a. failure to undertake weekly waterlow assessments in accordance with paragraph 4.2 and 4.3 of the policy;
    b. failure to carry out and/or adequately record daily skin inspections in accordance with paragraph 4.4 of the policy;
    c. failure to carry out a waterlow assessment when Mr. Mishabi was identified as having what were believed to be pressure ulcers on the 15th March 2023 in accordance with paragraph 4.3 of the policy;
    d. failure to consider increasing the frequency of skin inspections and carry out and/or adequately record any skin inspections between the identification of ulcers on the 15th March 2023 and the admission to hospital on the 17th March 2023 in accordance with paragraph 4.4 of the policy; and
    e. failure to make a datix incident report when grade II lesions were identified on the 15th March 2023 in accordance with paragraph 4.7 of the policy; and
    f. failure to provide adequate monitoring and oversight of the implementation of the policy in Mr. Mishabi's case in accordance with paragraph 5 of the policy. .
2. SAH Governance, Quality Assurance and Serious Incident processors
    a. SAH had not identified the issues with compliance with the policy before the inquest and could offer no explanation for how/why the failures occurred and persisted.
    b. No serious incident investigation had been carried out by SAH into Mr. Mishabi's death because it was mistakenly believed that the ulcers developed during the admission to hospital between the 17th March and 2nd April 2023. However, it was acknowledged in a

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| | statement from [redacted] of the 14th September 2023 that there were records showing ulcers were present from the 15th March 2023.<br>c. [redacted] SAH Deputy Medical Director, gave evidence that the failures to comply with the policy ought to have been identified by review of the physical health dashboard in monthly ward governance huddles and the monthly divisional Integrated Quality and Performance meeting (IQPR). As there had been no investigation into what went wrong she could not explain why these systems did not work. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 27 December 2023. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted] and University Hospitals of Birmingham.<br><br>I have also sent it to Birmingham and Solihull Intergrated Care Service and the CQC who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **1 November 2023**<br><br>Signature:  <br><br>**Emma Brown**<br><br>**Area Coroner for Birmingham and Solihull** |