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 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 13 October 2021, I commenced an investigation into the death of Tammy Mary Louise WATKINS, aged 36, which concluded by inquest held before me sitting with a Jury between 9 and 20 October 2023. The Jury recorded a Narrative Conclusion detailing multiple failings in Tammy's care which probably more than minimally contributed to her death. The Jury found that Tammy's death was contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Tammy Mary Louise Watkins was detained pursuant to s.45(5) of the Mental Health Act 1983 at the Women's High Secure Service, Rampton Hospital, Nottinghamshire, when she swallowed a plastic twistable crayon (approx. 17 – 20cm in length), which perforated her bowel, causing her death on 6 June 2021. Tammy was assessed as being at high and ongoing risk of ingesting foreign objects, a risk which had materialised on many occasions prior to her death, and often lead to hospital admission. Her risk of self-harm by ingestion led to the lawful use of mechanical restraints, comprising of mittens, a bio belt, eyesight or arm's length observations, controlled and supervised access to items when spending time out of her mittens, and a total restriction on Tammy having free access to personal items. On 22 March 2021, hospital staff provided Tammy was a twistable crayon to use while her mittens were removed. The twistable crayon had not been risk assessed or approved for use by Tammy's MDT, who were responsible for setting her care plan. In those circumstances, the twistable crayon ought not to have been provided to her. If the crayon had been presented to the MDT, her Consultant Psychiatrist would not have approved its use as it would have posed an obvious risk of serious harm if ingested due to its size and plastic structure. Instead, alternative child-safe small wax crayons could have been used to meet the same therapeutic purpose. At this time, the Trust did not have any documented system that set out the requirements for the MDT to approve the use of risk items, but this was nevertheless an expectation on the MDT, which they failed to complete. There is no clear or consistent record of who was observing Tammy or what items she had been granted access to on 22 March 2021. Despite the crayon being noted as "missing" from the pack, no incident report was completed, nor was the Security Manager alerted or any ward level plan initiated to seek to locate the risk item. Tammy started to present with symptoms of a complication of swallowing the item the next day. She reported nausea after eating, vomiting and epigastric tenderness. Mental health staff escalated her

	symptoms to the physical healthcare team. Tammy reported to the Advanced Clinical Practitioner that she could feel the twistable crayon inside her. The ACP made a plan to monitor for any deterioration and to discuss with the GP the following day. She was not escalated for investigations at the local hospital despite the size of the missing item and Tammy reporting feeling it inside her. The Trust failed to have in place a formal policy relating to the management of the ingestion of foreign bodies. This meant that staff were not all working to a clear plan of how to monitor for, detect and respond to the medical complications of ingesting foreign bodies. The MDT failed to have in place a care plan specific to Tammy's risk of swallowing, setting out how this should be managed and escalated by ward staff. There was no continuing, co-ordinated investigation to seek to locate the twistable crayon. On the evening of 16th May 2021 Tammy was observed to be vomiting in her toilet and at the same time reaching into the toilet. When asked, Tammy reported that she had swallowed a toothbrush. An out of grounds visit was arranged to take Tammy to Bassetlaw District General hospital. Tammy was examined at Bassetlaw General Hospital and was given an x-ray at 01:33am on 17th May 2021 which did not reveal any foreign bodies. Tammy was booked for an ultrasound scan later that day but was discharged at approximately 9:30am and returned to Rampton Hospital before this could be completed. Staff seem to have taken the negative x-ray result as evidence that there were no foreign bodies in Tammy's system. Many staff were unaware of the limitations of x-ray in relation to non-radiopaque items or the extent of the imaging. On the evening of 4th June 2021 Tammy reported discomfort and anxiety due to constipation. Given the timing and symptoms we feel this is likely to be the beginning of Tammy's deterioration. No actions beyond further observations are recorded to have taken place, staff appear to have taken Tammy's constipation entirely at face value. There is no evidence that the twistable crayon was being considered at this point. Tammy spent most of the day of 5th June 2021 in bed due to worsening symptoms. It is recorded that a mechanical restraint review was undertaken by the duty doctor, but it is unclear whether any physical examination of Tammy was undertaken at this point. By the evening of 5th June Tammy's temperature and heart rate had begun to spike and mental health staff became concerned. The same duty doctor was contacted during the evening by ward staff as Tammy continued to deteriorate. The duty doctor did not attend the ward or examine Tammy and advised ward staff to provide Tammy with paracetamol. This represents a missed opportunity to have recognised the deteriorating patient and to have sought medical attention. There is no record at this point that Tammy's symptoms were linked in any way to foreign body ingestion, despite Tammy voicing concern that she may have perforated her bowel. Tammy's symptoms continued to worsen throughout the early hours of 6th June 2021, including high pulse rate and temperature, anxiety, abdominal pain and vomiting, escalating to projectile vomiting and apparent 'faecal' vomit. The Hospital Trust failed to adhere to the NEWS2 Policy when Tammy was acutely unwell. NEWS2 was not recorded as frequently as required, at times the readings were incomplete, and the total score was not acted upon in accordance with the policy. This led to an underestimation of Tammy's clinical risk, and multiple missed opportunities to have rendered care in an acute hospital which would probably have prevented her death The physical healthcare team and the on-call Duty Doctor failed to recognise Tammy was a deteriorating patient and failed to take steps to arrange her timely transfer to an acute hospital for treatment of her perforated bowel. Over the weekend of 5-6 June 2021 there was a breakdown in communication between the ward staff, physical healthcare staff, duty doctor, and site management as to Tammy's signs and symptoms which led to a delay in her being transported to hospital to receive treatment for her condition Tammy continued to deteriorate throughout the morning of 6th June 2021, until shortly after 2pm when Tammy's symptoms were recognised by the physical healthcare team to be so severe that an ambulance would be required to take Tammy to hospital. A number of miscommunications between staff, added to the lack of a clear escalation protocol for staff to follow, resulted in a delay to the ambulance being called, because staff were unclear who should call the medical emergency. The Hospital Trust accepts that multiple failings in Tammy's care probably more than minimally contributed to her death. Neglect contributed to her death.

5	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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: 1. Poor Quality Acute Physical Healthcare in the mental health setting Tammy's death demonstrates a further example of a failure by medical staff to recognise a deteriorating patient and a subsequent delay in escalating for acute secondary care intervention. Her death comes after repeated concerns have been raised about the quality of the Trust's physical healthcare service in secure settings since 2018 (when Angus Bowie died from sepsis due to a perforation), in 2019 (when Christopher Howard Smith died from a pulmonary embolus), in 2020 (when Alexander Braund died from a chest infection) and in 2021 (when Michelle Louise Whitehead died from Hyponatraemic Encephalopathy). At each of those inquests, the Trust committed to improving the quality of physical healthcare across all secure settings and yet the same poor quality has prevailed in Tammy's care. These are examples of preventable deaths and the similarity in themes across them is exceptionally worrying. Action needs to be taken at the most senior level to effect meaningful change to the quality of physical healthcare across all secure settings at which the Trust provides services, recognising this class of patients as exceptionally vulnerable to deterioration as they are unable, either through mental health challenges and/or incarceration, to access healthcare services of their own volition. 2. Failure to Adhere to the National and Local National Early Warning Score (version 2) Policy This is a repeated theme identified at inquest and in previous Prevention of Future Death reports. Staff remained unclear at the inquest about how frequently vital signs ought to be taken, where and how to record the values, and what action should be taken depending on the score. 3. A lack of robust policy relating to Ingestion of Foreign Bodies I heard evidence that the Trust is in the process of drafting a policy, but it became clear during evidence that the policy is not yet sufficiently robust. The policy needs to cover the assessment of risk when access is permitted to risk items, where such a risk assessment is stored and who is responsible for its review of content, what to do when ingestion is suspected including how this should be managed medically and what security measures need to be taken to locate the item. 4. Emergency Medical Calls There was significant confusion in this case as to who should call a medical emergency and how information should be relayed to the ambulance service. It had been recognised early in the day by the Security Team that Tammy may require an out of grounds medical transfer, but it was not until much later in the afternoon, when Tammy was in cardiac arrest, that an ambulance was called. The Security Team expected the physical healthcare team to place the call, the physical healthcare team expected the ward to place the call due to proximity to the patient. Evidence called at the inquest established continued confusion amongst staff as to how an emergency should be managed. This appears to be a training issue.

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 4 March 2024. 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 -Tammy's Family Doncaster and Bassetlaw NHS Trust I have also sent it to - Nottinghamshire Police Care Quality Commission Health and Safety Executive NHS England as Commissioners for the healthcare services subject to this report who may find it useful or of interest. 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	**Dated: 5 January 2024** **Miss Laurinda Bower** **HM Area Coroner** **Nottingham and Nottinghamshire**