Regulation 28: Prevention of Future Deaths report

Nimo OSMAN (died 23 April 2022)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted]** **Chief Executive Officer** **East London NHS Foundation Trust** **Robert Dolan House** **Trust Headquarters** **9 Alie Street** **London E1 8DE**
1	**CORONER** I am Ian Potter, assistant coroner, for the coroner area of Inner North London.
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 3 May 2022, an investigation was commenced into the death of NIMO OSMAN, then aged 30 years. The investigation concluded at the end of an inquest with a jury, heard by me between 1 July 2024 and 5 July 2024. The inquest concluded with a short-form conclusion of natural causes. The medical cause of death was: 1a hypoxic ischaemic brain injury (unknown aetiology) II pulmonary thrombo-embolism, pneumonia, schizophrenia
4	**CIRCUMSTANCES OF DEATH** At the time of her death on 23 April 2022, Nimo Osman was in state detention because she was subject to a Hospital Order (in accordance with sections 37 and 41 of the Mental Health Act 1983). Ms Osman was admitted to Rosebank Ward (a psychiatric intensive care unit) at the Tower Hamlets Centre for Mental Health, which is on the Mile End Hospital site, on 5 April 2022. The

	Tower Hamlets Centre for Mental Health is operated by the East London NHS Foundation Trust. Ms Osman's principle mental health diagnosis was one of schizophrenia. Between 5-13 April 2022, Ms Osman spent a significant period of time in seclusion. On 19 April 2022, she was observed in a communal area of the Ward in an unresponsive state. A 999 call was made to the London Ambulance Service; however, shortly afterwards, Ms Osman was noted to become responsive and more alert. She was assessed by two doctors on the Ward who considered the most likely explanation was that Ms Osman was over-sedated. A decision was made to cancel the ambulance. Ms Osman was kept under observation and was noted to improve in following 24-hours and blood test results came back within normal limits. Ms Osman collapsed on the Ward on 21 April 2022. An ambulance was called and she was transferred to the Royal London Hospital, where she died on 23 April 2022 as a result of hypoxic ischaemic brain injury.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence 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:- (1) Following the discovery of Ms Osman's collapse on Rosebank Ward on 21 April 2022, it took staff a significant number of minutes to recognise that instead of just lying on the floor, Ms Osman was actually unrousable. A few minutes later a nurse arrived on the scene, who decided to summon the duty senior nurse (DSN) by radio, rather than activating the alarm system, which would have summoned the rapid response team sooner. The DSN contacted the duty doctor to inform them that there was a medical emergency, prior to calling an ambulance. In total, Ms Osman had been on the floor and unresponsive for over half and hour before an ambulance was called. I also viewed the CCTV evidence covering this course of events. I heard evidence from a consultant neurosurgeon and a consultant neuroradiologist. Their evidence was such that, in Ms Osman's case

this delay would not have made a difference because she had suffered a catastrophic brain injury and her condition was likely to have been unsalvageable from the moment she was found unresponsive on the floor. However, I consider that a delay of circa 30 minutes in calling an emergency ambulance raises a considerable risk, if repeated in the case of another patient requiring emergency treatment at hospital.

I was initially reassured by the evidence of a very senior member of nursing staff (Nurse A) about the work that has been done to educate all staff that anyone can call 999 for an ambulance if they consider it necessary, without seeking the advice of colleagues or the specific approval of a doctor. I was told by Nurse A that they were confident that the education and training undertaken with staff had had a positive impact and that a delay of this kind was unlikely to be repeated in the future.

However, a senior nurse (Nurse B) who was on duty at the time of Ms Osman's collapse told me in their evidence (over two years after Ms Osman's death) that nursing staff cannot and would not call an ambulance of their own volition. Nurse B told me that she would only ever call an ambulance if told to do so by a more senior clinician. Nurse B went on to tell me that it was often the case that by the time an ambulance had been called and arrived, a patient would die; the manner in which this evidence was given led me to form the view that the Nurse B seemed to think that this was 'just one of those things that happens'.

While I was told by Nurse A (who seemed genuinely concerned) that this matter would be escalated and addressed, I was concerned that over two years since Ms Osman's death this view was still held by a senior and experienced member of the nursing team who led a team of more junior nurses. My concern was such that I am not reassured that sufficient steps have been taken to prevent the recurrence of such a risk in the future.

(2) I heard evidence from Nurse A, in the absence of the jury, about East London NHS Foundation Trust's 'Patient Safety Serious Incident Review Report' (the SI Report). I was taken through the detailed 'Action Plan' that was devised as a result of the various 'service delivery problems' (SDP), 'care delivery problems' (CDP), and 'additional lessons learned' (ALL) that were identified as a result of the SI Report.

	Not all of the SDPs, CDPs or ALLs are of such seriousness that I consider that they create a risk of future deaths unless action is taken. However, some of them do, in my opinion, reach that threshold. While the evidence of Nurse A and the accompanying Action Plan did provide prima facie reassurance that action has been taken, the evidence of Nurse B (who, as previously stated is relatively senior and experienced) has significantly undermined what I heard from Nurse A. The undermining of that evidence and reassurance from Nurse A, leads me to conclude that there is, at the very least, a realistic possibility that the learning and apparent changes put in place have not necessarily been fully embedded with all relevant personnel within East London NHS Foundation Trust. As such those concerns and risks persist. For this reason, I consider that further reassurance is required in relation to the following matters of concern: (a) CDP2 – 'Staff should consider whether patients' behaviour might be due to being physically unwell and not assume that this is due to their mental health condition.' This concern relates, in part to the delay in calling for an ambulance (as per (1) above), but in my view it also has potentially wider implications for other patients. (b) CDP3 – 'As per Physical Healthcare Policy, v.14.1, Feb 2021, 7.6, all patients should have a VTE risk assessment form completed and a VTE assessment on admission to the in-patient unit.' While in Ms Osman's case the expert evidence from a consultant histopathologist was that pulmonary thromboembolism was not a causative factor in her death, I consider that this matter does raise potentially significant risks for other patients. (3) With regard to the East London NHS Foundation Trust's policy in relation to Venous Thromboembolism, I noted during the course of the evidence that this appeared to possibly conflict with NICE guidelines in some respects. There also appeared to be aspects of the policy that were ambiguous and open to different interpretations. I was told the policy remains in force and unchanged. The concern here is that possible ambiguity may lead to a non-universal interpretation of the policy, thereby putting patients at risk.
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe that 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 the report, namely by 7 October 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: (a) Ms Osman's mother, via her legal representatives. 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. She may send a copy of this report to any person she 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 publication of your response by the Chief Coroner.
9	**Ian Potter** **HM Assistant Coroner, Inner North London** **12 August 2024**