MR G IRVINE
SENIOR CORONER
EAST LONDON
East London Coroners Court, Adult Learning College, 127 Ripple Road, Barking, IG11 7PB
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted] Chief Executive Officer, East London Foundation Trust, 9 Alie Street, Goodmayes, Ilford, IG3 8XJ [redacted] 2. RT Honorable Therese Coffey, Secretary of State for Health & Social Care, 39 Victoria Street, Westminster, London, SW1H 0EU [redacted]
1	**CORONER** I am Graeme Irvine, senior coroner, for the coroner area of East 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 19th March 2022 I commenced an investigation into the death of Sophia Ayuk age 34 years. The investigation concluded at the end of an Article Two compliant inquest held on 18th and 19th January 2023. I arrived at a narrative conclusion. *"Sophia Abunaw Ayuk died in hospital on 18th March 2023 as the result of a pulmonary embolism. A deep vein thrombosis had developed in her left calf due to Sophia sitting motionless in her room on the day of her death.* *Sophia's behaviour on 18th March 2022 was due to her mental illness.* *Ms Ayuk had not taken any food or drink for at least two days prior to her death.*

	Dehydration may have contributed to the development of Ms Ayuk's thrombosis." The medical cause of death was determined following a post-mortem examination; *1a Pulmonary embolus* *1b Deep vein thrombosis* *II Schizophrenia (treated)*
4	**CIRCUMSTANCES OF THE DEATH** Ms Ayuk had been diagnosed with Hebephrenic Schizophrenia since 2013, her illness was treatment resistant and consequently, was treated with Clozapine. Ms Ayuk had been treated in the community and in hospital to manage her symptoms. In October 2021 Ms Ayuk suffered a relapse of psychosis and was admitted under S.2 of the Mental Health Act to a mental health ward for treatment. After a period of stabilisation Mrs Ayuk was discharged home but returned shortly thereafter when symptoms returned in January 2022. At the time of her death Ms Ayuk had yet to be successfully titrated back on to Clozapine and consequently, was experiencing symptoms of her illness On 18th March 2022 Ms Ayuk was observed by staff to remain in her bedroom all day. Sophia sat, fully clothed and motionless on a chair for most of the day. Sophia would not respond to verbal prompts and declined food and drink. At 20.45.49 Ms Ayuk was seen to emerge from her bedroom and walk down a corridor to the main area of the ward. Moments later Sophia fell to the floor and a patient alerted staff. Staff made an emergency call for the rapid response team and went to Sophia' assistance. Ms Ayuk was breathing and conscious at that time. Sophia began to deteriorate and 999 was called at 21.04. Paramedics responded promptly and on arrival found Sophia unresponsive but breathing. No pulse could be found and CPR was commenced. Resuscitation continued for 90 minutes until Sophia was declared deceased.
5	**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 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. At no time during the two periods of Ms Ayuk's inpatient care was she assessed for venous thromboembolism (VTE) risk in contravention of trust policy. 2. Instructions given to monitor and record Ms Ayuk's food and fluid intake were not adequately followed.
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 **17th March 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 Interested Persons; the family of Mrs Ayuk and the Care Quality Commission. I have also sent it to the local Director of Public Health 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 other 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.
9	**[DATE]** 20th January 2023 **[SIGNED BY CORONER]** 

East London
NHS Foundation Trust

Office of the Interim Chief Medical Officer
Trust Headquarters
5th Floor
9 Alie Street
London E1 8DE

T [redacted]

Private & Confidential

Mr Graeme Irvine
Senior Coroner
East London Coroners Court
Adult Learning College
127 Ripple Road
Barking
IG11 7PB

[redacted]

17 March 2023

Dear Sir,

RE: Regulation 28 Response for Sophia Ayuk

This is a formal response to your Regulation 28 report dated 20 January 2023 where you set out concerns relating to the care of Sophia Ayuk whilst under East London NHS Foundation Trust's **(the Trust's)** care.

I understand that at the inquest into Ms Ayuk's death you heard evidence from the Trust's Serious Incident **(SI)** review author outlining the learning that has taken place as a consequence of her death. However, you remained concerned about the risk of future deaths in relation to the following two areas:

1) At no time during the two periods of Ms Ayuk's inpatient care was she assessed for venous thromboembolism (VTE) risk in contravention of Trust policy; and

2) Instructions given to monitor and record Ms Ayuk's fluid and food intake were not adequately followed.

I wish to assure you and the family of Ms Ayuk that the Trust has reviewed the issues highlighted by the Regulation 28 report and has planned or undertaken the actions outlined below.

VTE Assessment

I understand that you heard oral evidence at inquest that the Trust proposed the following actions to ensure that VTE risk assessments are undertaken in accordance with the Trust's policy and best clinical practice:

1) A full review of the Trust's VTE policy;

[redacted]

2) A VTE Screening and Assessment Clinical Alert was disseminated across the Trust;

3) Changes were made to the new doctors' induction and junior doctors handbook to include information on VTE assessments;

4) Anti-psychotic medication has been added as a consideration on the Trust's VTE assessment tool;

5) The Trust's monthly two day physical health training programme now includes a session on VTE risk; and

6) A yellow card warning was raised with the manufacturers of the anti-psychotic, Zaponex through the Medicines Health Regulations Authority (MHRA) to alert to two patients who have both passed away from pulmonary embolism whilst on Zaponex.

7) The Trust has been trialling Power BI (a data analytics tool) in order to monitor compliance with VTE risk assessments.

Since the inquest took place the following further actions have been undertaken with the expectation that they will improve VTE risk assessment compliance:

1) An Advanced Clinical Practitioner (ACP) has started in the role of Consultant Nurse in Physical Health at NCfMH. She reviews physical health on the in-patient wards. If she has concerns about the physical health of in-patients, including around VTE assessments, she addresses them with staff during daily, morning safety huddles.

2) The Trust's electronic medical records system (RiO) was updated to include a pop-up reminder to seek a VTE risk assessment if someone's presentation changes every time nurses update the Observations and Measurements Form.

Since this further work, the Trust's power BI and doctors task list results have shown that NCfMH's compliance with VTE assessments has improved significantly.

Food and Fluid Intake Monitoring

I understand that you also heard oral evidence at inquest about the Trust's plan to improve fluid and food intake monitoring on in-patient wards. The associated actions were as follows:

1) The Trust implemented a new nutrition policy that highlights the importance of food and fluid monitoring for in-patients;

2) The Trust recruited specialist staff to advise on service user nutrition:

    a. A Band 7 Specialist Dietician was hired to provide (Trust-wide) nutritional guidance.

b. A Band 5 Dietician post has been approved specifically (Trust-wide) on nutrition. The role is currently being recruited internationally; and

c. The new ACP, Consultant Nurse in Physical Health at NCfMH (as above) will review all aspects of service user physical health including nutrition.

3) The Trust introduced a series of training measures in relation to nutrition on in- patient wards:

a. The Trust's monthly two day physical health training programme now includes a session on food and fluid charts;

b. A new learning module on nutrition screening is now live on the Learning Academy; and

c. A newly launched nutrition and dietetics page can be found on the Trust intranet with advice and resources for in-patient ward teams.

4) A dietician referral system has been introduced to provide advice and guidance on complex cases.

5) There are on-going plans to add the St Andrews Nutrition Screening Instrument (SANSI) nutrition and malnutrition screening form to RIO.

Since you expressed your concerns in the Regulation 28 report. NCfMH has undertaken the following additional steps to address the issue of staff compliance with food and fluid chart completion:

1) Daily food/fluid chart checks are done by senior nurses to ensure completion.

2) Matrons now do weekly night checks that include review of food/fluid charts.

3) A new template for decision making for commencing/terminating food and fluid chart monitoring has been developed and is in use.

I hope I have provided reassurance to you and the family of Ms Ayuk about the learning that has taken place as a consequence of her sad death.

Yours sincerely,

[redacted]

[redacted]
Interim Chief Medical Officer