	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Mr Neil Carr OBE Chief Executive Midland Partnership Foundation NHS Trust Mellor House Corporation Street Stafford ST16 3SR
1	**CORONER** I am Mr Andrew Haigh senior coroner for the coroner area of Staffordshire South
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 24 August 2018 I commenced an investigation into the death of Maureen Margaret Jarvis aged 72 years. The investigation concluded at the end of the inquest on 10 September 2019. The conclusion of the inquest was 'naturally occurring ulcer that was not diagnosed until after it had burst' with the death having resulted from a perforated duodenal ulcer.
4	**CIRCUMSTANCES OF THE DEATH** (a) Maureen Margaret Jarvis (known as Mandy) was compulsory detained under section 3 of the Mental Health Act at the George Bryan Centre (GBC) Tamworth. On the 15th August 2018 she was taken to Good Hope hospital where she died on the 17th August 2018 due to the effects of a burst ulcer. (b) At times staff at GBC were aware of Mandy being in pain. A full physical examination did not take place on admission although this was policy, nor at any other time during the rest of her time at GBC. Mandy did not provide her consent and it was deemed not appropriate to force her. The lack of full physical examination is a possible causative factor in her death. A further consideration is the failure to keep correct and accurate records. The level of personal care Mandy received could have been improved.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed a matter 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 **MATTER OF CONCERN** is as follows. – During her final admission to the George Bryan Centre Mrs Jarvis did not have a proper medical examination by a doctor. The reasons given for this were that she would not consent and that her condition never warranted this being done on a non-consensual basis. Among other witnesses I heard helpful evidence from the

	Consultant Psychiatrist [redacted] who indicated that this was a difficult area and also from [redacted] (the lead author of the Serious Incident Review) who believed there was a policy about this but could not be specific. It strikes me that there should be a clear policy about physical health examination of admitted psychiatric patients and this should be disseminated to all staff involved.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 6 November 2019. 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: Irwin Mitchell solicitors for the Jarvis Family Capsticks solicitors for your Trust. I have also sent it to the following persons who may find it useful or of interest: Care Quality Commission University Hospitals Birmingham NHS FoundationTrust. 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	**11 September 2019** ..... Andrew A Haigh HM Senior Coroner for Staffordshire (South) Coroner's Office No 1 Staffordshire Place Stafford ST16 2LP Tel No: 01785 276127 sscor@staffordshire.gov.uk