REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

Pauline May Pryor

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive of NHS England**
1	**CORONER** I am Dr E Emma Carlyon, the Senior Coroner for the coroner area of Cornwall and the Isles of Scilly
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** **An Investigation into the death of Pauline May Pryor was opened on 17th July 2015 and an inquest opened on 20th January 2016. An Inquest hearing was held on 14th November 2017 at Truro Municipal Buildings, Truro where the cause of death was found to be 1a Bronchopneumonia 1b Chronic Obstructive Pulmonary Disease II Renal failure, Lithium Toxicity and the death was considered to be the result of natural causes.**
4	**CIRCUMSTANCES OF THE DEATH** **Pauline Pryor suffered from bi-polar affective disorder and was being treated with Lithium. She was a resident of Trevaylor Nursing Home, Newmill Road, Gulval. On 9th July 2015 she was found in her room with reduced conscious with the occasional arm jerking. She was admitted to the Royal Cornwall Hospital, Treliske, Truro and diagnosed with acute kidney injury, severe metabolic acidosis, septic shock of uncertain cause and lithium toxicity. She received renal replacement therapy which improved her kidney function and lithium toxicity. She deteriorated and died on 13th July 2015 from bronchopneumonia as result of her severe chronic obstructive pulmonary disease.** **She was on Lithium which required her to have quarterly blood tests which due to communication issues between the GP surgery and Nursing Home did not occur. A reply to a letter from the mental health service to the GP was not actioned due the GP not receiving due to the e-mail not being received by the GP for unknown reasons or being chased up.**
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 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. –

	• Mrs Pryor suffered from bipolar affective disorder and was on Lithium treatment which had been successful for many years in controlling her mood. Patients on Lithium are required to have quarterly blood tests to check kidney function and lithium levels. This was not carried out for a number of reasons to do with unclear communication between the Nursing Home and GP surgery. The practice did have in place a computer system to highlight test/reviews for certain groups of patients based on "Quality Outcome Framework Targets" (QOF) guidelines and were unaware these did not necessarily mirror the NICE Guidelines or Local Prescribing /Care Guidelines such as in the case of Lithium Toxicity • A Blood test on 29th April 2015 showed Mrs Pryor's kidney function dropped (EGFR 25) and despite a lithium test being requested by Nursing Home and GP it did not occurred. As a result of the kidney function test result the GP wrote to Mrs Pryor's Consultant Psychiatrist for advice on medication. The Psychiatrist replied by e-mail on the 15.6.15 and advised the GP to reduce and stop the Lithium medication. The E-mail was sent to the GP Practice e-mail but was not seen by the GP for reasons unknown nor was the reply chased up
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. 1. To highlight the importance/requirement of good clear communication between health agencies when medical and nursing care is shared between the Mental Health Trust, GP and Nursing Homes especially where the patient is suffering from Mental Health issues 2. To ensure that all GP's are aware the QOF targets do not necessarily mirror NICE Guidelines or Local Prescribing /Care Guidelines e.g. Lithium Treatment; and the requirement for GP's to have their own systems in place to monitor the timeliness of tests/reviews
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 12th March 2018. 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 [redacted] of Cornwall Partnership Trust, [redacted] Chief Operating Officer of Swallowcourt, [redacted] of Alverton GP Practice. 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	**[DATE]** **[SIGNED BY CORONER]** **12/01/2018** Elizabeth Emma Carlyon