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Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

26th January 2021

Dr N Shaw
HM Coroner for County of Cumbria
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Cumbria
CA13 9PT

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[redacted]

[redacted]

Dear Dr Shaw

RE: Inquest into the death of Liane Davenport
Regulation 28 Report to Prevent Future Deaths Response

We write in response to your Regulation 28 Report dated 10th October 2019 following your investigation into the death of Liane Davenport. This response has been prepared by Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust ("The Trust") and addresses the concerns as set out by you.

As you are aware Mental Health Services at the time of Ms Davenport's death were provided by Cumbria Partnership NHSFT. As of 1st October 2019, those services are now provided by the Trust.

Please note that we have only recently been made aware of this Regulation 28 Report as it was not addressed to the Trust (this was initially sent to Cumbria Partnership NHS Foundation Trust ('CPFT') and has recently been sent to the Trust) which is why there has been a significant delay in providing a response.

The issue you raised within your regulation 28 report is as follows:

Should monitoring of blood levels of powerful antipsychotics be considered and recommended for patients on long term high dose treatment, particularly as they become older and more frail.

As far as we are aware, there was no indication during the course of the inquest that you were considering a Regulation 28 report in relation to the above and the evidence given by [redacted] confirmed that Ms Davenport was being monitored by the physical health team within the CMHART in response to the high doses of medications that she was taking.

Response

The Trust recognises the concerns that have been raised with regards to the monitoring of blood levels of patients on long term high dose treatment and in particular, powerful antipsychotic medication.

An investigation was carried out by CPFT (prior to its merger with the Trust) which we understand was provided to HM Coroner in advance of the inquest hearing. This investigation evidenced that Ms Davenport's physical health was monitored in accordance CPFT guidance at the time i.e. Ms Davenport attended CPFT for regular monitoring to identify any adverse physical health effects from the antipsychotic medication she was prescribed. This basic physical health monitoring included:

1. *Monitoring and recording any side effects of treatment;*
2. *Monitoring weight;*
3. *Measuring weight circumference annually;*
4. *Taking pulse and blood pressure annually;*
5. *Fasting blood glucose levels, HbA1c and blood lipid levels annually;*
6. *ECG conducted annually;*
7. *Advice provided on healthy lifestyle intervention; and*
8. *Ms Davenport to attend annual physical health review with the CMHART Physical Health Clinic.*

It is also noted in the investigation report that there was evidence of good communication with Ms Davenport's GP between 2008 and December 2019 with regard to physical health monitoring and high dose antipsychotic treatment ('HDAT') and CPFT CMHART staff proactively chased up missed physical health clinic appointments by conducting home visits and escorting the patient to the appointments.

Whilst Ms Davenport's physical health was monitored as specified above, we note that she could have qualified for more regular monitoring of her physical health as she was on HDAT, in line with RCPsych guidance. We do, however, understand that the HDAT policy was not approved in CPFT until approximately 4 months after Ms Davenport's death (1st March 2019) and as such, the relevant clinicians were acting in accordance with CPFT guidance at the time. In addition, we note that, in any event, neither basic nor HDAT monitoring would have involved the monitoring of plasma levels of the specific antipsychotic medication that Ms Davenport was on (Quetiapine and Amusulpiride) and this mode of investigation is not recommended in routine clinical practice by NICE, RCPsych or by the British Association of Psychopharmacology as the assessment of antipsychotic intolerance (or 'toxicity') is a clinical finding primarily associated with worsening side effects such as extrapyramidal effects, sedation, confusion and ECG changes.

In light of the above, the Trust considers that the care provided to Ms Davenport particularly in relation to her physical health monitoring was appropriate in the circumstances. However, to provide assurances to HM Coroner, the Trust has reviewed the measures which are in place to ensure that a patient's physical health is sufficiently monitored when they are on HDAT for prolonged periods of time.

We have attached the Trust policy on HDAT monitoring (alongside the Trust Guidance to be read alongside this policy) for ease of reference which details the additional monitoring requirements for adult patients prescribed HDAT.

To summarise, the additional monitoring requirements/tests/measurements are as follows:

- ECG;
- Urea and electrolytes;
- Liver function;

- Prolactin;
- Blood pressure and pulse (sitting/lying/standing);
- Temperature;
- Clinical signs of hydration;
- Glucose regulation;
- Review of side effects including a specific review for movement disorder; and
- Review of PRN medication.

The Trust policy sets out the importance of each investigation/test and the frequency for conducting each investigation/test. You will note that the additional monitoring requirements do not include the monitoring of blood levels in accordance with the relevant national guidance as set out above.

We hope that the information provided offers you the necessary assurances that the Trust have invested time, effort and resource into investigating the issues you have highlighted with a view to improving patient care and safety and reducing the risk of any adverse incidents or outcome in the future.

Should you wish to discuss any of the above further, please contact [redacted]

Yours sincerely

[redacted]

Executive Director of Nursing and Chief Operating Officer