MISS N PERSAUD
HER MAJESTY'S CORONER
EAST LONDON
EAST LONDON CORONERS, ADULT LEARNING COLLEGE, 127 RIPPLE ROAD, BARKING, IG11 7PB
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: 10342061

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Ministerial Correspondence and Public Enquiries Unit, Department of Health and Social Care, 39 Victoria Street, London, SW1H 0EU **Email:** [redacted] **2.** [redacted], National Medical Director, The National Quality Board, NHS England **Email:** [redacted]
1	**CORONER** I am Nadia Persaud, area 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 the 5 January 2021 I commenced an investigation into the death of Shirley Alice Moloney. The investigation concluded at the end of the inquest on 26 May 2022.

	The conclusion at the end of the inquest was that Mrs Moloney had died from natural causes. There were some concerns however that her underlying mental health diagnosis had been overlooked in the months leading up to her death.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Moloney suffered from long standing paranoid schizophrenia. In more recent years, she also suffered from hiatus hernia, Barretts's oesophagus and severe frailty (very low BMI from at least 2019). She was admitted to a care home in April 2019. Mrs Moloney suffered from periods of mental distress, with psychotic symptoms. Mrs Moloney received anti-psychotic medication, but did not receive any care from the community mental health team after April 2020. In December 2020, there was a clear deterioration in her clinical state and she was deemed to be near to the end of her life. Anticipatory (palliative care) medication was prescribed for her. On the 9 December 2020 she suffered three vomits in her care home. She was not administered anticipatory medication to relieve her symptoms at this time. In the early hours of the 10 December 2020, Mrs Moloney was found to be unresponsive in the bedroom of her care home. The emergency services were called and a paramedic pronounced her life extinct on scene. It is likely that she died as a result of aspiration pneumonia. There is no evidence that her death was rendered unnatural, due to any lack of care.
5	**<u>CORONER'S CONCERNS</u>** The **MATTERS OF CONCERN** are as follows: (i) Mrs Moloney suffered from paranoid schizophrenia. There was evidence of her mental state deteriorating in the months leading up to her death. Her mental health deterioration is likely to have impacted upon her physical health deterioration, but she was not under the care of community mental health services in the last nine months of her life. (ii) The inquest heard that older age psychiatric teams are very poorly resourced, nationally. This is compounded by an absence of adequately trained staff, to address mental health in residential home settings. The inquest also heard that there is a lack of establishments suitably designed for dual physical/mental health needs. (iii) Once discharged from an older age community psychiatry team, it can take a very long time to access the teams again. These delays can act as a deterrent to GPs in referring patients to community mental health teams. (iv) The inquest heard that mental health concerns can often be overlooked towards the end of life. Structures for accessing care for physical symptoms towards the end of life are well developed. Accessing care and support for psychological distress is not so well defined. Care homes and nursing homes tend to have mainly general nurses, as opposed to mental health nurses. They also have easy access to GPs and geriatricians. There is a perceived lack of easy access to older age psychiatry teams, by care homes and nursing homes. (v) As mental health and physical health are so closely inter-linked, the lack of older adult psychiatry resource for elderly patients, gives rise to a risk of future deaths.
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe 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 this report, namely by **4 August 2022**. 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 am sending a copy of my report to the Chief Coroner, to the family of Mrs Moloney, the CQC, the local Director for Public Health and to the other interested persons to the inquest. The report is also being copied to the Royal College of Psychiatrists and the British Geriatrics Society. 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	**9 June 2022**