REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Secretary of State for Health and Social Care** **2. Chief Executive of Greater Manchester Mental Health NHS Foundation Trust**
1	**CORONER** I am Catherine McKenna, Area Coroner for the area of Greater Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 25 June 2021 an investigation into the death of Ania Sohail was commenced. The investigation concluded on 30 January 2023 at the end of the inquest that was held before a jury. The jury recorded the following conclusion; *'Suicide with intent.* *The death was contributed to by the ineffectiveness of all searches but in particular to the search on 18 June 2021, inadequate post-leave assessment and the omission of Safety Plans which reflect the risks posed to Ania on 18 June 2021.* *In respect of the online pharmacies, there was a:* *a) Lack of integrated system or records which could be accessed by multiple pharmacies* *b) Lack of access to the GP Summary Care Records, other pharmacy supplies; and* *c) Lack of consent to the sharing of information.'*
4	**CIRCUMSTANCES OF DEATH** On 19 June 2021, Ania Sohail collapsed in the lounge area of Griffin Ward, Junction 17 in Prestwich after ingesting [redacted] Propranolol tablets which she had secreted onto the ward following periods of home leave. She was taken to North Manchester Hospital and died later that day. A post-mortem examination established that the cause of death was Propranolol toxicity. Ania had been an inpatient on Griffin Ward since June 2020 and for the final 9 months of the admission was detained under section 3 of the Mental Health Act 1983. She had a diagnosis of Emotionally Unstable Personality Disorder and a history of self-harm and suicide attempts. During her admission to Griffin Ward, Ania had purchased Propranolol medication on seven separate occasions from four different on-line pharmacies. On each occasion, Ania had completed an on-line questionnaire in which she denied having a mental disorder and declined consent for the prescriber to share information with her GP. The prescribers were unaware that Ania was accessing Propranolol from multiple on-line pharmacies and that Ania was concealing the fact that she was an inpatient at a psychiatric unit by ordering the Propranolol to be delivered to her home address. The prescribers accepted the information provided by Ania at face value and had they been aware of the above information, it would have altered their prescribing decisions. Before the fatal overdose on 19 June 2021 and whilst an inpatient on Griffin Ward, Ania had taken overdoses of Propranolol on 10 March and 5 June 2021. Searches of her room had been undertaken following each overdose. Home leave had been suspended following the first overdose before being

gradually reintroduced. Following the second overdose, home leave was reinstated on the basis that pre and post leave assessments would be undertaken and Ania would be searched on return to the ward. Searches were conducted on a trauma informed basis and therefore were limited in nature.

Ania's first home leave following the second overdose was on 18 June 2021. When she returned from leave that evening, Ania was searched by a mental health support worker who confiscated two belts from her bag. Ania denied having any other contraband items on her person. There is no documented evidence of the two belts having been found on Ania that evening or that this was handed over to the nurse in charge of the shift. The nurse in charge of the shift has no recollection of being informed of the two belts or of undertaking a post-leave assessment. The entry within the Day notes does not evidence whether or not a post-leave assessment did in fact take place that evening.

Ania collapsed in the lounge area of Griffin Ward at lunch-time the following day. She was on 1:5 observations. The evidence from the support worker with responsibility for undertaking the checks between 10am and 12noon was that for the majority of that time Ania was in her room with the door closed and that the checks were undertaken by knocking on her door every 5 minutes to check that she was alright.

Following her collapse, Ania was conveyed to North Manchester General Hospital where attempts at resuscitation continued until deemed futile. Her death was verified at 15:36 hours that afternoon.

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.

<u>The MATTERS OF CONCERN in relation to on-line prescribing are as follows:-</u>

(1) Whilst each individual pharmacy had in-house safety checks to safeguard against over-prescribing by their own pharmacy, there is no integrated system in place which would alert a prescriber to prescriptions that have been dispensed by other on-line pharmacies. As a result, it is currently possible for a patient to obtain excessive quantities of medication by simply placing multiple orders with different on-line pharmacists.

(2) There is no requirement for the on-line pharmacies to share information with the patient's GP. This means that, in the absence of the patient's consent to share information, the online prescriber is reliant on the accuracy and truthfulness of the history provided by the patient.

(3) Lack of information sharing also creates a risk that a GP or Pharmacist Prescriber may unwittingly prescribe a medication that is contraindicated with a medication that has been dispensed through an on-line pharmacy.

<u>The MATTERS OF CONCERN in relation to the provision of mental health care on Griffin Ward are as follows:-</u>

(1) The Recovery & Discharge Plans contained inaccurate information regarding Ania's consent to share information with her mother. The evidence was that this was an entry made in error in June 2020 and was not picked up by any of the nurses who updated the Recovery & Discharge Plan over the subsequent 11 months.

(2) The Recovery & Discharge Plans did not address the risks associated with Ania's procurement of Propranolol from on-line pharmacies. The evidence was that an update of the Recovery & Discharge Plan involved members of nursing staff simply adding a note that the overdoses had taken place. The Plan did not show that any meaningful thought had been given to addressing the particular risk associated with the procurement of on-line medication.

(3) Mandatory refresher training on basic aspects of nursing care such as record keeping, searches, care-planning, undertaking pre- and post-leave assessments and confidentiality is not provided to staff.

(4) There is no requirement for the outcome of negative personal searches to be documented in the records and consequently there is no ability to effectively audit whether searches are taking place and the treating team are unable to assess a patient's level of compliance with rules around bringing contraband items onto the ward.

(5) Searches undertaken of Ania's room following the overdoses on 10 March and 5 June 2021 were ineffective and did not uncover the Propranolol that Ania had been stockpiling.

(6) Documentation on which 1:5 observations are recorded does not evidence that a check has taken place every 5 minutes. Instead the current documentation, simply requires one signature per hour. There is therefore no mechanism by which observations can be effectively audited.

(7) There is no requirement to make a separate entry evidencing that a post-leave assessment has been undertaking. The post-leave assessments are currently subsumed within Day Notes and do not clearly state whether an assessment was undertaken, what was discussed and the outcome of the assessment.

6 **ACTION SHOULD BE TAKEN**

In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 **5 April 2023** I, the Area 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 namely:-

Mr and Mrs Sohail
General Pharmaceutical Council
General Medical Council
Care Quality Commission
MHRA
UK Meds
[redacted]

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 from. 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.

Date: 7 February 2023 Signed: