REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Stockport Integrated Care Partnership
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester 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 22nd December 2022 I commenced an investigation into the death of Michael Brian Sullivan. The investigation concluded on the 16th May 2023 and the conclusion was one of **Narrative: Died of natural causes exacerbated by lithium toxicity.** The medical cause of death **was 1a) Bronchopneumonia; II) Bipolar disorder, Lithium toxicity, chronic obstructive pulmonary disease**
4	CIRCUMSTANCES OF THE DEATH Michael Brian Sullivan had schizophrenia and was bipolar. He took lithium medication. He deteriorated at his home address and was admitted to Stepping Hill Hospital after concerns were raised by his family. He was found to have pneumonia and lithium toxicity, a complication of his bronchopneumonia and related to his dehydration. He deteriorated despite treatment and died at Stepping Hill Hospital on 17th December 2022.
5	<u>CORONER'S CONCERNS</u> 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. – The evidence before the inquest was that Mr Sullivan was a vulnerable person with a complex mental health history. The inquest heard evidence

	that GPs could access a Crisis Review Team to assess patients such as Mr Sullivan. However, the evidence before the inquest was that there seemed to be delays between referrals and assessments. It was unclear if these were due to a lack of understanding by GPs on how the CRT could be used or how patients were prioritised within the CRT or a lack of effective triage by GPs before referral or the CRT following referral. In his case the concern was raised by his family on 13th December 2022 with the GP. The GP referred him to the CRT that day indicating he needed an assessment on 14th December 2023 for confusion following a fall and a possible UTI. At the assessment on 14th December 2023 at 11am Mr Sullivan was seriously unwell.
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 15th August 2023. 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 namely 1) [redacted] and 2) Stockport Metropolitan Borough Council, who may find it useful or of interest. 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	**Alison Mutch** **HM Senior Coroner**  **20.06.2023**