Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Lister House Oakwood**
1	**CORONER** I am Susan EVANS, Assistant Coroner for the coroner area of Derby and Derbyshire
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 19 January 2023 I commenced an investigation into the death of Melvyn Lee BLOUNT aged 64. The investigation concluded at the end of the inquest on 21 September 2023. The conclusion of the inquest was that: Melvyn Blount tied a [redacted] ligature [redacted]. From the evidence it has not been possible to determine what his intention was when he did so. In the days leading up to his death he was increasingly confused and expressing delusional thoughts. He died from asphyxiation which was caused by the act of him tying the ligature [redacted].
4	**CIRCUMSTANCES OF THE DEATH** Melvyn Blount experienced a sudden and significant decline in his mental health and was having delusional thoughts. He had a telephone consultation with a mental health nurse on the 10th of January 2023 who concluded that the most likely cause was lack of sleep. Mr Blount was prescribed sleeping tablets. The mental health nurse was a non prescriber and sought the assistance of a GP to prescribe zopliclone. His condition deteriorated and on the 12th of January his wife instigated a further telephone consultation by the mental health nurse who referred him for an appointment with a General Practitioner to investigate whether there was a physical cause for his decline in mental health. In that telephone consultation his family requested a face to face appointment and he was referred back to the mental health team. On the 13th of January he was seen by a second mental health nurse who was concerned that his presentation was due to a mental disorder rather than arising from a physical cause but ordered blood tests to exclude that as a possibility. Melvyn Blount was displaying delusional thoughts during his consultation. The nurse did not instigate any further investigation of, or seek support for, his potential mental disorder and was reliant upon his family providing that support and keeping him safe. His family were not warned not to leave him alone. On the 14th of January 2023 Melvyn Blount [redacted] causing him to asphyxiate. Emergency services were called by his wife and he was taken to the Royal Derby Hospital where he was found to have died.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

	The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) Mr Blount had a consultation with a non-prescribing mental health practitioner at his GP practice who considered that he would benefit from the prescription of zopiclone. As a non prescriber he had to seek the assistance of a GP to actually prescribe the tablets and this was done after discussion between the two professionals. There was no direct contact between the GP and Mr Blount. The mental health practitioner was aware of a relevant drug alert but did not inform Mr Blount. From the evidence it is apparent that at the point of prescribing any drugs a GP will receive a pop up on their computer if there are any drug alerts pertinent to the drug being prescribed. The GP will then be able to determine if the drug alert is relevant and if so should be passed on to the patient. It was clear that if the GP had direct contact with the patient it would be their responsibility to digest the alert and inform the patient. What remains unclear is what should happen to ensure that an alert is digested and disseminated when it is the GP who receives the alert but is prescribing at the behest of a non prescriber and so does not see the patient. The lack of a clear policy gives rise to the risk that drug alerts are not seen by non-prescribers and therefore not communicated or are being seen or known about but still not communicated. It also remained unclear from the evidence whether the GP prescribing the dug remains ultimately responsible for ensuring that patients are properly informed and if they do, how they can satisfy themselves that relevant information is passed to the patient without seeing them personally.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by November 16, 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: Mr Blount's family [redacted] 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 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 by the Chief Coroner.
9	**Dated: 21/09/2023**

	 **Susan EVANS** **Assistant Coroner for** **Derby and Derbyshire**