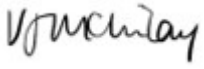
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: St. Andrew's Healthcare**
1	**CORONER** I am Vanessa McKinlay, HM Assistant Coroner for Birmingham and Solihull
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 24 January 2023 I commenced an investigation into the death of Jason Mark BAYLEY. The investigation concluded at the end of the inquest. The conclusion of the inquest was; Natural Causes.
4	**CIRCUMSTANCES OF THE DEATH** Jason suffered from paranoid schizophrenia and was detained under section 3 of the Mental Health Act 1983 for treatment at St. Andrew's Healthcare. He was prescribed clozapine on a long term basis, which carried a recognised risk of constipation which was treated with a regime of laxatives. Despite this, Jason had chronic constipation which was likely to have been developing over a period of many years. In December 2022 Jason's severe and chronic constipation led to intestinal pseudo-obstruction as a result of which he died at Queen Elizabeth Hospital in Birmingham on 28 December 2022. Following a post mortem/Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: **1a Intestinal pseudo-obstruction (Megacolon)** **1b Obstipation** **1c** **II Lower respiratory tract infection**
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. The **MATTERS OF CONCERN** are as follows. - 1. Mr Bayley became unwell on 25/12/22 and was admitted to hospital the following day with severe constipation, from which he died on 28/12/22. 2. On most days between 4/12/22 and 25/12/22 when he was a detained patient on Speedwell Ward at St. Andrew's Healthcare, Mr Bayley refused to take at least one of his daily doses of lactulose which he was prescribed as part of a regime of laxatives for constipation. While these refusals were documented in the Electronic Prescribing and Medicines Administration document, there were fourteen occasions when it was incorrectly

	documented that all medication had been taken under the 'Medication Adherence' section in the Rio notes. 3. The Rio notes are the daily working records to which all staff have access. The reporting of medication adherence is specifically prompted in the Rio notes. It is of concern that, owing to a breakdown in communication between staff, the Rio notes repeatedly stated that all medication had been taken when it had not. 4. I am concerned that accurate documentation of whether medication has been taken in the Rio notes is an important safeguard against harm and a mechanism to promote appropriate care planning. I am concerned that there may be a risk to the life of some patients if staff understand that medication has been taken when it has not.
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 13 December 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: [redacted] I have also sent it to the Department of Health and Social Care, CQC. 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	**17 October 2023** Signature:  **Vanessa McKinlay** **HM Assistant Coroner for Birmingham and Solihull**