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 Low Moor Medical Practice**
1	**CORONER** I am Crispin OLIVER, HM Assistant Coroner for the coroner area of West Yorkshire Western Coroner Area
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 15 April 2020 I commenced an investigation into the death of John HOARE aged 62. The investigation concluded at the end of the inquest on 12 October 2023. The conclusion of the inquest was that: John Hoare died a natural death occurring while, preventably, detained under the Mental Health Act 1983.
4	**CIRCUMSTANCES OF THE DEATH** John Hoare was born on 03 February 1958. He died at 06.30am on 31 March 2020 at Airedale General Hospital. He had a diagnosis of schizoaffective disorder. He had admissions at Bradford Royal Infirmary between 15 November and 04 December 2019 and 14 December and 14 January 2020. He suffered from confusion, cognitive and memory problems and lithium toxicity. He was discharged from Bradford Royal Infirmary to Norman Lodge Care Home. This resulted in a change of medical practice from Shipley to Low Moor Medical Centre. Concurrently his established Community Mental Health Care Coordinator changed - he did not have one on discharge from hospital. The new one was allocated on 24 January and was able to first meet with John on 05 March. John required a number of prescribed medications for his condition, including, crucially, lithium citrate. This was clearly referenced in the discharge letter and the Norman House care plan. Lithium was dispensed and administered between 15 and 24 January per his prescription. It was not supplied with the next 28 days medication. On 20-21 January a decision was made by GPs that blood tests were required before the prescription for lithium could resume. These confirmed by 04 February that John`s lithium was below therapeutic levels. For the purposes of the next prescription period, commencing from 17 February, however, lithium was not included. There had been GP oversight of this but there was a failure to recognise and act on the omission. John`s mental health declined critically from 03 march 2023. Advanced Nurse Practitioners attended Norman House 2-3 time per week. On 04 March, for the first time, an Advanced Nurse Practitioner examined John. She said she would prescribe lithium. It was dispensed and administered on 05 March. Therefore John did not receive lithium between 24 January and 05 March. By the time it was resumed his condition was so severe that he required to be detained under Section 4 of the Mental Health Act 1983, in the early hours of 06 March 2020. He was admitted to the Bracken and then Fern wards of Airedale Centre for Mental Health. While admitted, albeit there were no other reported cases among staff or residents, he contracted Covid 19. This required his admission to Airedale General Hospital on 27 March 2020, where he subsequently died. He remained

	detained under section at the time of his death. James had been in a dependent position while at Norman House. Lithium could have resumed no later than 04 February and should have resumed no later than 17 February 2020, and it did not. There was a gross failure to provide basic medical attention insofar as: there was reference to lithium on the discharge summary; Johns's case required specific attention; there was obvious evidence on system 1 available to be seen; John`s needs as a new patient should have been carefully considered; lithium prescribing, dispensing and administration should attract particular care and attention; there was an inherent importance in not delaying or interrupting lithium; there had been numerous requests and reminders from the care home about the provision of lithium; there was a material delay during which nothing was done by the GPs` surgery; there was failure to identify that delay; that failure led to the precise consequence that the lithium was intended to avoid. As a result of this gross failure, John required to be detained and admitted to Airedale Centre for Mental Health. The omission of the lithium contributed to his condition more than other factors. John contracted Covid 19 while admitted at Airedale Centre for Mental Health, most likely in the Fern Ward, possibly from a member of staff. While it is possible that he was at a greater risk of infection while in the Fern Ward than he would have been at Norman House, or any other environment at that time, it cannot be so concluded on a balance of probabilities. Therefore it cannot be concluded, on a balance of probabilities, that his death from Covid 19 was caused by his being detained under section, albeit the detention was preventable.
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) Firstly, it has to be recorded that the GP who gave evidence for Low Moor Medical Centre was a conspicuously honest witness and clearly exceptionally caring. He had been devastated by what had occurred in this case. But the fact remains, secondly, that there had been a gross failure to provide basic medical attention in relation to lithium prescribing and dispensing that resulted in John being sectioned. While a finding, on the balance of probabilities, that the detention caused the death was not available, it does remain a possibility.
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 December 07, 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

	[redacted] who may find it useful or of interest. 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: 12/10/2023**  **Crispin OLIVER** **HM Assistant Coroner for** **West Yorkshire Western Coroner Area**