OFFICE OF THE
SENIOR CORONER
for the County of West Yorkshire
(Eastern District)

His Majesty's Coroner's Office
The Coroner's Courts
Burgage Square
Wakefield WF1 2TS

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Waterloo Manor Hospital** **2. In Mind Healthcare Group Limited**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner, for the Coroner area of West Yorkshire (East)
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 Coroner's (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 31 May 2023 I commenced an investigation into the death of Amanda Richardson, aged 40. The investigation concluded at the end of the Inquest on 30 August 2024. The conclusion of the Inquest was a narrative conclusion, in which the medical cause of death was: **1a [redacted] and [redacted] Toxicity.**
4	**CIRCUMSTANCES OF THE DEATH** Amanda Richardson, aged 40, had been transferred from prison to a low secure mental health hospital called Waterloo Manor Independent Hospital in Leeds, under the provisions of a Hospital Order made under the Mental Health Act 1983. She was prescribed the drug [redacted], amongst other medication. On Saturday 29 April 2023, Ms Richardson was pronounced dead by a paramedic after her lifeless body was found on the floor of her bedroom. Toxicology Analyses subsequently revealed [redacted] at a very high level well within the range encountered in fatalities, along with [redacted] It transpired she had in error been prescribed [redacted] at double the stipulated maximum dose.
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. The evidence taken at the inquest revealed that Ms Richardson had been prescribed [redacted] for a period of about six months at double the stipulated maximum dose. The pathologist expressed the view that the "very high" level of [redacted] found in her blood on toxicology analysis could possibly account for her death on its own. She had also taken [redacted] Her death was attributed to the toxicity of both the [redacted] and [redacted] in combination. 2. It was admitted that the prescription of [redacted] at the rate of [redacted] mg/day was double the [redacted] mg/day stipulated maximum (without additional monitoring being undertaken) and was made in error. This situation went unnoticed for some six months, until her death. There was no effective system of review in the hospital in this period. The pharmacist appears to have dispensed the drug without querying the high dose. The nurses who administered the drugs did not question it. The MDT meetings which took place did not check the dose, or reflect upon its potential interaction with the several other medications prescribed. Overall, there was no effective resilience in the hospital's systems to safeguard against drugs bring prescribed or administered in error. 3. On 19.4.23, Ms Richardson was permitted unescorted leave in the community under S.17 MHA 1983. She did not return. She did, however, voluntarily reappear at the hospital the following day, albeit under the influence of illicit drugs and alcohol. Evidence was given that nurses reported having searched Ms Richardson on her return, but no adequate written record was made to confirm the nature or duration of the search, nor by whom it was conducted, in breach of hospital policies. 4. Ms Richardson died some 9 days later. Despite the seriousness of the 19.4.23 incident, no searches were carried out in her room or the hospital grounds in the period following her return. The toxicology and pathological evidence indicated that she had taken heroin shortly before her death. Her room was not searched even after her death, as assumptions were wrongly made that her death was due to a cardiac event. 5. Some time after hear death, Ms Richardson's clothing and belongings were returned to an aunt. She searched through them and found various plastic "wraps" which were taken to the police and subsequently tested and confirmed as containing [redacted] and [redacted]. The inference is that these were present in her bedroom at the time of her death. 6. The inquest was unable to establish how or when Ms Richardson obtained illicit illegal drugs. Concerns were expressed as to the adequacy of the security arrangements in this low secure mental health hospital as at April 2023. 7. In fairness to the hospital, it should be acknowledged that an Internal Serious Incident Review has taken place. Evidence was taken from the Group Deputy Chief Executive in relation to the overhaul of security systems, pharmacy review procedures, staff training and record keeping which has taken place since Ms Richardson's death.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 1 November 2024. 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 who may find it useful or of interest. :

	[redacted] Aunt The CQC The GMC West Yorkshire Police 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	Signed:  KEVIN McLOUGHLIN Senior Coroner West Yorkshire (E) Date: 9 September 2024