REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chief Executive Officer, The Priory Group-**
1	**CORONER** I am Christopher Long, Area Coroner for the coroner area of Lancashire and Blackburn with Darwen
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 2 November 2023 I commenced an investigation into the death of Kevin Anthony Ince, age 55 years. The investigation concluded at the end of the inquest on15 November 2024. The conclusion of the inquest was natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Mr Ince was detained under the Mental health Act 1983 at Kemple View Hospital, Langho, Blackburn in Lancashire. On 24 October 2023 he pressed his call bell as he was unwell. It was noted that he was short of breath and panting. Oxygen was administered due to low oxygen saturation levels, whilst waiting for an ambulance. Mr Ince was taken to Royal Blackburn Hospital where his requirement for support with oxygen continued. Whilst in hospital he underwent a series of diagnostic tests whilst treatment continued over the following days. Unfortunately, his condition deteriorated, and he did not recover. He died on 25 October 2023. He died as a result of right ventricular failure caused by acute Interstitial pneumonitis as a result of vaping associated lung injury.
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 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. – (1) The inquest heard clear evidence of regular refusals of necessary and appropriate medical treatment by patient detained under the Mental Health Act 1983, over several years with insufficient consideration of steps that were then appropriate including a lack of steps to persuade the patient, insufficient consideration of the powers under the Mental Capacity Act 2005 and insufficient consideration of utilising s.63 of the Mental Health Act 1983 (2) Insufficient action was taken when patient detained under the Mental Health Act 1983 routinely declined food over a prolonged period.

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 Tuesday 14 January 2025. 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: Family and Sadben and Whalley Medical Group. I have also sent it the Care Quality Commission 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	**[DATE] 18 November 2024**