Regulation 28 Report to Prevent Future Deaths
Derby and Derbyshire Integrated Care Board Response

Derby and Derbyshire Integrated Care Board (DDICB) would like to extend our sympathies to the family and friends of Aaron Atkinson. Please find below the ICBs response and future plans in regard to the Regulation 28 Report to Prevent Future Deaths.

If there are any areas which you feel you would like more information or to discuss in person this will be arranged.

Aaron was found deceased on the morning of 20 April 2023 at his home address. His death was completely unexpected.

As his cause of death was not known a postmortem examination was conducted including toxicology. The pathologist's opinion was that Aaron had died due to a seizure and positional asphyxia.

Aaron's mother was doubtful of the cause of death proposed and pressed for a second postmortem which was undertaken by a different pathologist. That pathologist considered that a more likely cause of death was cardiac arrhythmia caused by Aaron's prescription of Risperidone (for behavioural regulation), and Ritalin (for ADHD – attention deficit hyperactivity disorder).

On the court's assessment of the evidence, applying the balance of probabilities, a probable medical cause of death cannot be determined.

The court notes that Aaron's medication reviews to check for any complications were conducted in line with local health guidelines. Aaron's last review took place in November 2021, but Aaron did not attend subsequent reviews which were offered.

The following report and action plan is in response to the matters of concern revealed through the course of the inquest as below. The concerns have been reviewed with actions to prevent future deaths captured in the action plan at the end of the report. This will be reviewed as per the timescales included within the report.

Coroner concerns

Whilst Aaron had annual GP reviews related to prescription of anti-psychotic medication (Risperidone, although the inquest heard that prescription of Ritalin was also a relevant factor, particularly in combination with Risperidone), to check for signs of adverse side effects and physical health complications, those reviews did not include ECGs (electrocardiograms) to check for signs of adverse effects on electrical activity of the heart. On the medical evidence before the inquest antipsychotic medication carries recognised risk of QT interval prolongation and lethal cardiac arrhythmias. It does not appear that the recognised risk of QT interval prolongation and lethal cardiac arrhythmias from long term prescription of antipsychotic medication is reflected in guidance to medical practitioners and prescribers, nationally or locally in terms of performing ECGs. The relevant NICE (National Institute for Clinical Excellence) guidance (web link below) refers to ECG testing under How should I monitor someone taking antipsychotics? and recommends

Electrocardiography (ECG) - after dose changes. Ideally, also annually. The local Derbyshire Integrated Care Board guidance (web link below) does not identify need for ECG to be included in annual monitoring in primary care unless if new medicines or changes to physical health have increased the risk of prolonged QTc arrange ECG. It appears there is lack of clarity and consistency for annual reviews to include ECGs where people are prescribed antipsychotic medication long term. Given the recognised risks explained at inquest then not providing annual ECGs for long term users of those medications appears to pose risk of death.

NICE web link: https://cks.nice.org.uk/topics/bipolar-disorder/prescribinginformation/antipsychotics/

Derbyshire web link (DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)):

https://www.derbyshiremedicinesmanagement.nhs.uk/assets/Clinical_Guidelines/Formulary_by_BNF_chapter_prescribing_guidelines/BNF_chapter_4/Antipsychotics_Prescribing_and_Management.pdf

Derby and Derbyshire ICB Response

Guideline review

The Coroner identified a variance between the local Joint Area Prescribing Committee (JAPC) recommendation, which states:

"If new medicines or changes to physical health have increased the risk of prolonged QTc arrange ECG" (page 9 of Derbyshire antipsychotic guidance),

and the NICE Clinical Knowledge Summary (CKS) recommendation:

"Electrocardiography (ECG) – after dose changes. Ideally, also annually."

It is also important to note that within the NICE CKS, the only medications where ECG monitoring is mandated are haloperidol, pimozide and sertindole (only available in UK on named patient basis – specialist use). Furthermore, the Summary of Product Characteristics (SmPC), of these medications varies slightly from the NICE CKS:

For Haloperidol

'A baseline ECG is recommended before treatment. During therapy, the need for ECG monitoring for QTc interval prolongation and for ventricular arrhythmias must be assessed for all patients.'

For Pimozide

'An ECG should be performed prior to initiation of treatment with pimozide, as well as periodically during treatment.'

Sertindole – SmPC unavailable as unlicensed.

For all other medications referenced, including Risperidone and methylphenidate, ECG monitoring is recommended as good clinical practice but is not mandatory.

Our considered position is that the ICB will amend the JAPC recommendation to align with the NICE CKS by advising ECG monitoring for all patients on antipsychotics after dose changes and ideally, also annually. This local change will be implemented while awaiting any future national guidance revisions from NICE, which would require country-wide adoption.

Non engagement with monitoring

Our local guideline will also be updated to reflect advice available on our JAPC guideline 'prescribing in primary care', which reinforces the importance of regular engagement. This is of particular importance with respect to antipsychotic medications:

ISSUING OF PRESCRIPTIONS
'The patient's condition is monitored appropriately, and prescriptions are not issued for patients who require further examination or assessment. This is particularly important in the case of medicines with potentially serious side-effects.'

To further support patients and their carers, an overview of the Derbyshire Healthcare NHS Foundation Trusts 'local support services' will be added to the guideline, including a link to the webpage. Colleagues can use this link to signpost patients to appropriate support networks should they wish. This link will also be accessible on our medicines management website for ease of access.

As part of the ICB's GP quality visits, data is included and discussed relating to the severe mental illness register/ reviews. The discussion at these visits includes a way of encouraging these patients to attend their reviews.

We have reached out to the named GP, to support any actions they identify. Our aim is to share learning across the system to enable the scaling of improvements. In addition to the actions identified above, we are looking to identify any practice processes for non – engagement from patients.

Actions to Address Concerns

In light of these points, the ICB is undertaking the following steps:

1. **Revision of Local Guidance**
    - Update Derbyshire antipsychotic prescribing guidance to add NICE CKS recommendations on annual ECGs for patients on antipsychotic therapy and after dose changes, matching NICE recommendations.
2. **Await NICE response**
    - Await NICE's response to case and potential updates to national guidance regarding ECG monitoring standards for patients prescribed antipsychotics

3. Shared learning

- Share lessons learned and guidance updates next steps with primary care clinicians and across relevant networks
- Share local support services link with colleagues across the system to raise awareness of support available to patients and carers that colleagues can signpost to.

Please see below a timeline of proposed actions

Action number	Overview of DDICB actions	Proposed completion date
INVESTIGATION AND SUPPORT		
1a	Review investigation and lessons learnt/ actions identified by the practice. With support of the ICB primary care quality team and ICB patient safety team, identify support required. Identify relevant lessons learnt from GP quality visits	6/10/25
1b	Review response from NICE and acknowledge local updates if required. Plan further actions based on potential guidance changes.	6/10/25
1c	Update JAPC guideline 'Antipsychotic Prescribing and Management for mental health conditions' and medicines management webpage, as identified above.	25/11/25
REVIEW AND COMMUNICATIONS		
2a	Extract shared learning from the practice and NICE responses and add lessons to be shared additionally to those raised above, into an incident report, ready to be shared with system colleagues. Learning report ratified through existing governance routes	6/11/25
2b	Collated learning to be shared through existing communications as identified above.	Following Derbyshire Prescribing Group (DPG) 4/12/25.
2c	At the Clinical Governance Leads meeting with general practice the Learning report	Following Derbyshire Prescribing Group (DPG) 4/12/25.

		will be discussed as part of the Patient safety standard agenda item.	