REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Medical Director of the Greater Manchester NHS Area Team**
1	**CORONER** I am Joanne Kearsley Area Coroner for Manchester South
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 the 6th October 2015 I concluded the Inquest into the death of David Baddeley date of birth 29.04.1972 who died on the 23.06.2015 at his home address 54 Chester Avenue, Dukinfield, Tameside. The cause of death was 1a) Hanging 2) Schizophrenia I recorded that the deceased had a history of Schizophrenia. At the time of his death he was not being prescribed his anti-psychotic medication. He died as a result of tying a ligature around his neck, at his home address. It is probably he was suffering from a deterioration in his mental health at the time he died. I reached an Open Conclusion as there was no evidence the deceased had intended to end his own life.
4	**CIRCUMSTANCES OF THE DEATH** As indicated Mr Baddeley, an extremely intelligent gentleman, had a very long standing diagnosis of Schizophrenia which was controlled with anti-psychotic medication. He had had a number of hospital admissions throughout his life. For the majority of his life Mr Baddeley had lived in the Tameside area. Approximately 4 years ago he moved to the Stockport area. He had a GP in Cheadle. Whilst in Stockport he had a number of admissions to Stepping Hill Hospital. His last admission being in 2013. In around September 2014 the Court heard evidence that the deceased moved back to the Tameside Area. He registered with the Ann Street Medical Practice in Denton and first attended the surgery in September 2014 for an unrelated condition. At this stage his manual records were not with the practice as these did not arrive until at least a month after he had registered. Due to the volume of patients and medical records the Court heard that it was not until the 9th March 2015 that a summary of his medical records was completed.

	Even then it was not clear that this was a patient with an underlying mental health condition. On the 30th March 2015 Mr Baddeley made an appointment with the practice and requested a repeat of his Amisulpride medication which he advised he was taking twice a day, although he did indicate he had reduced his dose due to side effects. At this stage his GP advised he would contact his previous Psychiatrist for further information as it was not possible from the information available to determine when he had last been seen. He also prescribed his Amisulpride medication for a period of 4 weeks. The Court heard that the information from the psychiatric services was not received until the 6th May 2015. However on the 1st May Mr Baddeley had attended the practice and advised the practice nurse that he had moved and would be registering with a new practice closer to where he now lived. On the 12th May he registered with the Davaar Medical Centre in Dukinfield and his records from Ann Street had been forwarded electronically. The Court heard that whilst the medical records are sent electronically GPs are not aware of which practice they are sent to. The Court heard that if the GP had known the details of the practice Mr Baddeley had registered with he would have spoken to them about his mental health issues and the fact that he appeared no longer to be under psychiatric services and was not receiving his anti-psychotic medication (save for the one prescription issued on the 30th March). The Court also then heard from a GP from the Davaar Medical Practice. He advised the Court that due to the fact that medical practices are on different computer systems, when Mr Baddelys' electronic records were received the fact that he was diagnosed with Schizophrenia was not obvious in the format they were received. On the 18th May Mr Baddeley attended for a new patient check and was seen by a Healthcare assistant, but this was limited and the Court heard that the Healthcare Assistant would not have been expected to have read all the electronic records which had been received. The Davaar Medical practice did not receive Mr Baddeleys written records until the 28th May 2015, these were not reviewed until the 15th June. When they were reviewed they were detailed as not requiring any action.
5	**CORONER'S CONCERNS** The concerns noted by the Court during the course of the Inquest are as follows: 1) That the transfer of a patients electronic records between medical

	practices can mean that key information is not highlighted due to the incompatability of the systems. 2) The practice which a patient is leaving is not notified of the new practice taking over the patients care so that doctors can speak and discuss any pertinent medical issues. 3) The length of time it takes for a medical practice to receive the full paper medical records. 4) Due to the volume of work the fact that it takes 8 weeks for a patients paper medical records to be reviewed and summarised. 5) The fact that the initial new patients health screenings did not note that Mr Baddeley had a serious psychiatric illness, which could have made him a risk to himself or indeed others as he was not taking his antipsychotic medication. 6) That when his paper records were reviewed on the 15th June nothing pertinent was thought required and again his mental health diagnosis and lack of medication not picked up.
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. It should be noted that both of the medical practices involved in this particular case had themselves noted flaws in the systems and taken steps to address some of the issues themselves, however the findings of the Court highlight an issue which may impact on medical practices across Manchester.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **16th December 2015** 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 namely, **the family of Mr Baddeley.** 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	**21.10.2015** **Joanne Kearsley Area Coroner**