REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Secretary of State for Health** **2. The Minister of Health, Welsh Assembly Government** **3. The Chief Executive, Cwm Taf University Health Board** **4. The Editor, British National Formulary** **5. The President, The British Association of Dermatologists** **6. The President, The Royal College of Psychiatrists**
1	**CORONER** I am Christopher John Woolley, Assistant Coroner, for the Coroner area of South Wales Central
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** In April 2017 I commenced an investigation into the death of Deidre Harvey. The investigation concluded at the end of the inquest where I sat with a jury between 16th and 27th July 2017.The medical cause of death was: 1.a Hanging. The jury returned a conclusion as follows: Accident contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Deidre Harvey had had a long history of bipolar disorder, having first undergone treatment in the 1990s. She had a long period of stability in the community between 2006 and 2016 but on October 13th 2016 her condition worsened and she was admitted to the Mental Health Unit, Royal Glamorgan Hospital. From admissions she was transferred to Ward 22 on 1st November 2016. She was discharged on 21st November 2016 but took an overdose on 24th November and a serious suicide attempt on 8th December. She was again admitted to the admissions ward after two days I HDU, and then on 4th January 2017 was transferred to Ward 22 again. She remained on that ward until her death on 10th April 2017. She was made subject to a Section 3 Mental Health Act order on 21st February 2017 and this was continued until her death. Deidre suffered from several concomitant physical condition including Systemic Lupus Erythematosus for which she was prescribed the drug Hydroxychloroquine. This had been administer34ed to her at 200 mg per day from mid-November 2016 until her death. At the time of her death blood analysis showed that she had accumulated toxic levels of this drug in her system (more than 15 mg/DL which is above the level at which cardiac arrhythmias have been noted (3.6 mg/L) and death (7.5 mg/DL). In the event however the pathologist did not attribute Deidre's death to Hydroxychloroquine toxicity. Deidre's mood from January to April was fluctuating. The team on Ward 22 also struggled to get her hyponatraemia under control and this compromised both the individual mood stabilisers and anti-depressants they were able to give, as well as the

	quantity at which they were able to give them. The team said they planned to give ECT but this had not been administered by the 10th April 2017. While the Hydroxychloroquine continued to be administered there was no dialogue between the mental health ward and the consultants treating her other conditions (dermatology and gynaecology). In February 2017 Deidre cut her wrists (13/2) and on the 20th February 2017 she made a disclosure to a nurse that she had attempted to hang herself with a dressing gown cord. She was placed on a Section 3 Mental Health Act order on the 21st February. In March Deidre and her daughter both reported that she was putting on a front, or putting on a mask. Her mood fluctuated but she made comments that she wanted to end it. On 10th April 2017 she appea4rd to be brighter and looking forward to going home. She went to the communal bathroom on the ward and told staff that she was having a shower at 8.40 am. At 8.55 am staff went into the bathroom and found that Deidre had died after attaching a ligature to her neck. The ligature used was a dressing gown cord which had previously been removed from her after a threat she made to hang herself with it. The cause of death was given by the pathologist as 1a Hanging.
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. – **Secretary of State for Health** 1. The inquest heard that patients on Mental Health Units often have significant physical problems which are treated by outside consultants, who may have little input into their care on the ward or may not even know they are there. In this inquest the consultant psychiatrist treating Deidre was not aware of the potentially toxic effects of the drug for her lupus. *The Coroner is concerned that outside consultants should have a more active input into the care of the mental health patient on a Mental Health Unit, in order that their expertise and knowledge is available to the treating consultant psychiatrist.* 2. The inquest heard that an obvious ligature point was identified in September 2016 in the Mental Health Unit, and yet bureaucratic processes meant that approval for funding the rectification of this ligature point was held up for months, with staff having to "manage" the risk. *The Coroner is concerned that there should be an expedited process for rectifying obvious ligature points on Mental Health Units* **Minister for Health, Welsh Assembly Government** 1. The inquest heard that patients on Mental Health Units often have significant physical problems which are treated by outside consultants, who may have little input into their care on the unit or may not even know they are there. In this inquest the consultant psychiatrist treating Deidre was not aware of the potentially toxic effects of the drug for her lupus. *The Coroner is concerned that outside consultants should have a more active input into the care of the mental health patient on a Mental Health Unit, in order that their expertise and knowledge is available to the treating consultant psychiatrist.* 2. The inquest heard that an obvious ligature point was identified in September 2016 in the Mental Health Unit, and yet bureaucratic processes meant that approval for funding the rectification of this ligature point was held up for months, with staff having to

"manage" the risk.

The Coroner is concerned that there should be an expedited process for rectifying obvious ligature points on Mental Health Units

Chief Executive – Cwm Taf University Health Board

1. The inquest heard of the Pod system on the Mental Health Unit in which items of danger to patients were deposited (and then possibly returned to the patient). There was no evidence of any effective system to identify who had what item, and when.

The Coroner is concerned that there should be an effective system to check on what is taken from a patient and then later returned to a patient.

2. The inquest heard that patients on Mental Health Units often have significant physical problems which are treated by outside consultants, who may have little input into their care on the unit or may not even know they are there. In this inquest the consultant psychiatrist treating Deidre was not aware of the potentially toxic effects of the drug for her lupus.

The Coroner is concerned that outside consultants should have a more active input into the care of the mental health patient on a Mental Health Unit, in order that their expertise and knowledge is available to the treating consultant psychiatrist.

3. The inquest heard that there was confusion between staff on the Mental Health Unit and the Community Psychiatric Nurse over management of risk for a patient admitted on the Mental Health Unit, with the result that responsibility for a Risk assessment might not be recognised.

The Coroner is concerned that there should be proper management and dissemination of risk management policies to frontline staff to avoid any confusion

Editor British National Formulary

Hydroxychloroquine
1. The expert evidence given was that Hydroxychloroquine (HCQ) is not contra-indicated in Appendix 1 of the BNF for anti-epileptic drugs. The manufacturer's leaflet however does contain a caution against using HCQ alongside anti-epileptic drugs. It is acknowledged that the text of the BNF does indicate that HCQ should not be used in case of neurological disorders (including epilepsy) but this does not catch patients like Dee who was on an anti-epileptic drug (Lamotrigine) for her bipolar condition but was not epileptic.

The coroner is concerned that the BNF might not fully describe the risk to patients taking Lamotrigine (or drugs of similar class or composition) alongside Hydroxychloroquine.

Royal College of Psychiatrists

Hydroxychloroquine
1. The evidence in the inquest showed that the psychiatrists treating Deidre were largely unware of the potential side-effects of Hydroxychloroquine which Deidre was received for her Systemic Lupus Erythematosus. These include mental changes and psychosis.

The Coroner is concerned that consultants treating other mental patients who are receiving this drug should be aware of these side-effects, and is concerned that there should be proper liaison with the consultant dermatologist over its toxic and potential metal health side-effects.

In General the Coroner is concerned that the psychiatrists treating a patient in a Mental Health Unit should have the benefit of specialist advice from outside consultants who

	may be treating the patient for a physical condition **British Association of Dermatologists** Hydroxychloroquine 1. The expert evidence received in this inquest revealed that Hydroxychloroquine could build up to toxic levels even with normal dosage. [redacted] of the Dept of Toxicology, Birmingham Heartlands Hospital reported that there is a clear cross-over between apparently toxic concentrations and apparently therapeutic concentrations. Dee at the time of her death had a concentration of approximately 25 mg/L and fatalities at 7.5 mg/L. *The Coroner is concerned that this drug should not be prescribed to a patient suffering from Lupus (which in itself is not life-threatening) without an awareness that toxic levels can build up even at the recommended dose.* *The Coroner is concerned that the dermatologist prescribing this drug should liaise with other consultants treating the patient for other conditions (in Deidre's case for her mental health problems) so that specialist knowledge about the toxic effects of this drug can be shared.* **CEO Alerts NHS** Hydroxychloroquine 1. The evidence in this inquest is that Deidre (who was a detained patient under Section 3 MHA) was being given a drug for a physical condition (Lupus) which can build up to toxic levels even at normal doses. The inquest heard that there is no routine checking of Hydroxychloroquine levels at clinical level, even though [redacted] said he thought that clinical monitoring of this drug might be important. *The Coroner is concerned that there may be other dependent persons suffering from lupus (or other conditions for which Hydroxychloroquine is prescribed in NHS hospitals in England and Wales) who may also have toxic levels of Hydroxychloroquine in their system unbeknown to their carers.*
	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe that 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 3rd October 2017. 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: 1 [redacted] (for Deidre Harvey's family) 2. [redacted] Head of Mental Health Nursing, Cwm Taf University Health Board 3. The Chief Medical Officer for Wales 4. The CEO of NHS England 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	**8th August 2017** **C J Woolley** **Assistant Coroner, South Wales Central**