	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: University Hospitals Birmingham NHS Foundation Trust**
1	**CORONER** I am Emma Brown Area Coroner for **Birmingham and Solihull**
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 07/02/2020 I commenced an investigation into the death of Francis Xavier Cooney. The investigation concluded at the end of an inquest on 5th August 2020. The conclusion of the inquest was Suicide.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a fall at home on 02/01/20 causing a scalp laceration which required hospital treatment. Further assessment in out-patients confirmed he needed surgery to repair the wound which was undertaken on 10/01/20. Post-surgery he remained in hospital and developed delirium which gradually settled. He had an assessment by the occupational therapist on the 21st and 22nd January 2020 at which he was orientated, did not appear confused, could manage his personal care and could perform simple tasks. Consequently, he was discharged home on 24/01/20. Following discharge, he appeared less independent than prior to his admission, he was more confused, he suffered another fall, although he showed no sign of any significant injury, and became anxious and concerned about his medications. On 27/01/20 he was found hanging from the bannister of the stairs at his residence and was declared deceased at 07.39. Following a post mortem the medical cause of death was determined to be: 1(a) HANGING
5	**<u>CORONER'S CONCERNS</u>** 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. Dr. [redacted], Consultant Geriatrician, made a change to Mr. Cooney's prescriptions for Amitryptyline and Nitrazepam. Although the fact of the change and the rationale for it were explained in "general terms" to Mr. Cooney at the time of the review on the 21st January 2020 and set out in the discharge summary, nothing was communicated to Mr. Cooney's daughter and next of kin, Ms [redacted], who also held lasting power of attorney for him. Following his discharge on Friday 24th January 2020, Ms [redacted] realised that the dose of Amitryptyline and Nitrazepam dispensed was half the usual dose. Mr. Cooney, who had dementia, had been found during his admission to lack capacity and had suffered multifactorial delirium during the admission, did not know why he only had half the expected dose of these medications, he did not recall the change and became anxious about it. It was agreed that they would contact his GP on Monday the 27th January to ask for a review of the medications. As Ms [redacted] had not been informed of the decision and the reason for it she could not explain it to her father and/or

	provide reassurance. Unfortunately, Mr. Cooney ended his life during the early hours of the 27th January. Mr. Cooney's suicide note included "I tried to sort the tablets out but couldn't" 2. For patients with a cognitive impairment there is a risk that if changes to medication made during an inpatient stay are not communicated directly to those caring for them, confusion will arise which could result in the medication being erroneously omitted or overdose. 3. Dr. [redacted] acknowledged that if Mr. Cooney had been a patient on the Geriatric Wards, rather than a plastic surgery patient, she would have communicated the fact and reason for change to Ms. [redacted] directly. She said she did not do so in this case because, as a Consultant providing an opinion for a patient under the care of another team, she did not view it as her responsibility. 4. Dr. [redacted] said that her practice had now changed, and she would always communicate such a decision to the NOK of a patient with a cognitive impairment. She was also aware that the facts of this case would be raised with other geriatricians within the Trust. However, it was not clear that this awareness will result in consideration of a new instruction/procedure that for all patients with dementia and/or significant cognitive impairment, any changes to medications made during an inpatient stay should be communicated to the NOK/carer by the clinician making the change regardless of the capacity in which they come to be reviewing the patient. 5. The Coroner is aware that this case has not been the subject of a root cause analysis or similar such investigation and is therefore concerned that the broader implications of this breakdown in communication will not have been identified.
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 5 October 2020. 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: Ms. [redacted]. 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	10/08/2020 Signature  Emma Brown Area Coroner **Birmingham and Solihull**