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. Bev Humphrey, Chief Executive, Greater Manchester Mental Health NHS Foundation Trust, Trust Headquarters, Bury New Road, Prestwich, Manchester M25 3BL. 2. The Chief Pharmacist, Hindley Health Centre Pharmacy, 17 Liverpool Road, Hindley, Wigan WN2 3HQ.
1	**CORONER** I am Alan Peter Walsh, HM Area Coroner for the Coroner Area of Manchester West.
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 27th June 2017 I commenced an Investigation into the death of Paul Geoffrey Mullen, 37 years, born 19th February 1980. The Investigation concluded at the end of the Inquest on the 6th November 2017. The medical cause of death was:- Ia Combined Toxic Effects of Heroin and Methadone. The Conclusion of the Inquest was Drug Related Death.
4	**CIRCUMSTANCES OF THE DEATH** 1. Paul Geoffrey Mullen (hereinafter referred to as "the deceased") died at [redacted] Wigan on the 22nd June 2017. 2. The deceased had been taking drugs from the age of 18 years and he was known to be a long term user of heroin, crack cocaine, diazepam and tramadol. He was well known to treatment services and he had numerous treatment episodes in Wigan and Leigh since 2008. 3. The deceased was referred to the Wigan & Leigh Recovery Service under the umbrella of Addaction (hereinafter referred to as "Addaction") following a referral from prison upon his release from prison on the 12th April 2016.

All referrals into Addaction go via Greater Manchester Mental Health NHS Foundation Trust (hereinafter referred to as "GMMH"), who also deliver any medical interventions. Addaction deliver recovery focused work for those affected by substance misuse and their families through specialist psychosocial one to one work and specialist tailored group work sessions to develop recovery focused plans.

The deceased was assessed by GMMH, which is the prescribing partnership for Addaction, and he was referred to Addaction for case management.

Following the initial assessment, a Recovery Plan was completed and objectives were agreed around substance misuse to stop illicit drug use and adhere to methadone treatment. The deceased was prescribed 60ml methadone daily, which was to be collected from a pharmacy on a daily basis.

The designated pharmacy was Hindley Health Care Pharmacy, 17 Liverpool Road, Hindley, Wigan (hereinafter referred to as "the Pharmacy")

4. Over the next 12 months the dose of methadone was varied and the deceased did not attend a number of appointments with Addaction.

   The last face to face appointment with Addaction was on the 26th April 2017 when the deceased attended Addaction without an appointment. At that time he was receiving 50ml methadone by a daily prescription which was collected from the Pharmacy each day, except Sunday. He was encouraged to seek further medical intervention in relation to his physical and mental health. He failed to attend a number of appointments with his Key Worker at Addaction in May and June 2017, including a medical review.

5. In spite of his failure to attend his appointments the deceased collected his methadone prescription on a daily basis from the Pharmacy and he was very diligent collecting his methadone prescription each and every day.

   On the 15th June 2017 Addaction sent a letter to the deceased explaining that he had missed four appointments with Addaction and that his failure to attend the next planned appointment on the 21st June 2017 would result in his methadone prescription being placed on hold. GMMH were informed of the letter by Email.

   On the 21st June 2017 the deceased did not attend an appointment with his Key Worker at Addaction and the Key Worker telephoned the Pharmacy asking them to place the deceased's prescription of methadone on hold to encourage his attendance at Addaction.

   On the 22nd June 2017 the Key Worker again telephoned the Pharmacy to check whether the deceased had attended to collect his methadone and whether he had been informed that the prescription had been placed on hold. The Key Worker was informed that the deceased had not attended and, in fact, had not collected the methadone on Monday the 18th June 2017, Tuesday the 19th June 2017 and Wednesday the 20thJune 2017.

The Key Worker emailed GMMH on the 22nd June 2017 to confirm the above circumstances.

6. At or about 14:55 hours on the 22nd June 2017 the deceased was diagnosed as having died at his home address at [redacted].

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:-

1. During the Inquest evidence was heard that:-

   i. The deceased was receiving a daily prescription of methadone to be collected and administered on a daily basis from the Pharmacy. The prescriptions were not collected from the Pharmacy on Monday the 18th June 2017, Tuesday the 19th June 2017 and Wednesday the 20th June 2017.

   ii. There is a system, referred to at the Inquest as a "red flag system", for a pharmacy to report the non-collection of a prescription of methadone when a patient has not collected the medication on three consecutive occasions. The evidence at the Inquest indicated that the purpose of the report by a pharmacy of non-collection is to enable the Key Worker to be made aware of the non-collection of the medication so that the Key Worker could take appropriate action to contact the patient and to check whether any concerns need to be addressed.

   iii. The Key Worker attached to the deceased was [redacted], who is a Key Worker employed by Addaction, and she gave evidence that the procedure relating to the deceased, and other patients, to report non-collection of medication is for the report to be sent by a pharmacy to GMMH and not directly to the Key Worker. In the case of the deceased, [redacted], the deceased's Key Worker, did not receive a report that the deceased had not collected his methadone on the above dates and she only became aware of his non-collection of methadone by her own enquiry when she telephoned the Pharmacy to request that the prescription of methadone be placed on hold.

   iv. [redacted] also gave evidence that some patients, particularly those patients who are known to be diligent and to collect their medication on time each and every day, may require a report of non-collection of medication earlier than three days because, in relation to those patients, a single failure to collect medication may raise concerns and require enquiries by the Key Worker as to any concerns, in view of the fact that those patients always collect their medication each and every day.

	v. GMMH is a Mental Health NHS Foundation Trust and is separate in terms of governance, even though working in partnership to an extent, from Addaction, which is described as a Drug, Alcohol and Mental Health Treatment Charity. Accordingly, any report relating to the non-collection of medication addressed to GMMH requires a further onward report from GMMH to Addaction. The governance of GMMH has no control over Practitioners employed by Addaction and GMMH and Addaction do not share computer reporting systems. 2. I request a review of the system referred to at the Inquest as the "red flag system" in relation to the reporting of patients who fail to collect prescribed medications, particularly where the patient is due to collect prescribed medications on a daily basis. The review should consider:- i. The reporting of a failure to collect prescribed medication direct to a designated and named Key Worker, who may not be within the employment of GMMH, to avoid the report being processed by an intermediary, who does not employ or control the Key Worker. The review should consider the most expeditious route to report the failure to collect prescribed medications to a Key Worker, who has the responsibility in relation to the patient and who will have direct contact with the patient. The Key Worker will be the most expedient method of contact with the patient. ii. The timescale in relation to a report being submitted to the Key Worker, taking account of the fact that the present three day timescale may not be appropriate for patients who are known to be very compliant and who collect prescriptions on a regular daily basis. In those circumstances the concern and the need to check the concern may arise after either one or two failures to collect the prescribed medication. iii. The training of pharmacy, mental health practitioners and any other healthcare professionals in relation to the reporting of failures to collect prescribed medication taking account of the circumstances relating to the case of the deceased, where the failure to collect the prescribed medication was not reported, as soon as practicable, after the third consecutive failure to collect the medication.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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 12th January 2018. 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] Mr Mullen's mother, [redacted] 2. [redacted], Service Manager, Addaction, Coops Building, 11 Dorning Street, Wigan WN1 1HR. 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	**Dated** **17th November 2017**	**Signed** **Alan P Walsh** **HM Area Coroner**