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.** Mr Ron Shields, Chief Executive of Dorset Healthcare University NHS Foundation Trust, 4-6 Sentinel House, Nuffield Industrial Estate, Poole BH17 0RB
1	**CORONER** I am Rachael Clare Griffin, Senior Coroner, for the Coroner Area of Dorset.
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 8th September 2017, an investigation was commenced into the death of Amanda Mary Spark, born on the 9th May 1971. The investigation concluded at the end of the Inquest on the 6th April 2018. The Medical Cause of Death was: 1a Combination of multiple drugs (Codeine, Zopiclone, Amitriptyline and Mirtazapine) and ethanol intake The conclusion of the Inquest was suicide.
4	**CIRCUMSTANCES OF THE DEATH** On the 3rd September 2017 the deceased, who suffered with depression, was found in a collapsed and unresponsive condition in the bedroom at her home address at Flat 3 Cedra Court, 4 Westby Road, Bournemouth.
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. Mrs Spark was a lady who suffered with her mental health and she had been engaging with Dorset Healthcare University NHS Foundation Trust (DHUFT) since 2009. On the 25th August 2017 she was admitted to the Royal Bournemouth Hospital, Bournemouth having taken an overdose of medication. She was assessed by the Psychiatric Liaison Team who are part of DHUFT and was discharged to the Crisis team within DHUFT.

   ii. She was seen daily by the Crisis team and during the visits they decided to change her medication regime so that the administration of this was supervised by the Crisis team staff. This decision was made in relation to the medication for her mental health. Mrs Spark was however also prescribed medication for her physical health. On the 3rd September she sadly died from an overdose of prescribed medication.

   iii. Evidence was given that although the GP is written to when there is a change in regime regarding the mental health medication, there is no action taken in relation to the physical health medication. This may be a matter for the GP to resolve but if a patient's access to medication is to be immediately changed by DHUFT employees, this should be addressed in relation to all medication not just mental health medication.

   iv. I heard evidence from the Psychiatric Liaison Team Lead and the Crisis Team Lead that there does not appear to be a policy in place at the Trust to deal with the communication of the supervision of physical health medication. If there is such a policy, they advised me that they are not aware of it.

   v. Once the access to medication has been identified as a risk to a patient and there is a need for the taking of it to be supervised, access to, and the taking of, all medication, not just mental health medication, should be supervised.

2. I have concerns with regard to the following:

   i. That there is no policy in place in relation to the supervision of prescribed physical health medication when a decision has been made to supervise the administration of prescribed mental health mediation. I would therefore request that DHUFT review their policies regarding the supervision of all medication a patient is prescribed and when and how to alert GPs, or other treating practitioners, regarding changes to mediation regimes and supervision.

   ii. If there is already such a policy in place to deal with both physical health and mental health mediation, then I would request that refresher training is undertaken to ensure all staff

	are made aware of the policy and the procedures to be adapted in such circumstances.	
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and/or your organisation 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, 14th June 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] Amanda Spark's mother I have also sent this report to Dr Purbrick the Medical Director of the Wessex Local Medical Committees LTD so that my concerns can be disseminated to the General Practitioners in Dorset. 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** **19th April 2018**	**Signed** **Rachael C Griffin**