REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1. [redacted] Executive Director of Quality and Nursing, Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups, c/o CommCen Building, Fort Southwick, James Callaghan Drive, Fareham PO17 6AR**
1	**CORONER** I am Caroline Sarah Sumeray, Senior Coroner for the Coroner Area of the Isle of Wight.
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 1st August 2018 I commenced an investigation into the death of Megan Nicole JONES, aged 28. The investigation concluded at the end of the inquest on 3rd April 2019. The conclusion of the inquest was "Megan Nicole JONES died pursuant to a recognised complication of a necessary medication regime." The medical cause of death was found to be: 1a Cardiac Arrhythmia 1b Intake of a higher than Optimal Combination Dose of Antipsychotic Medications 1c II
4	**CIRCUMSTANCES OF THE DEATH** 1) Megan Nicole JONES was born on 19th March 1990. At the time of her death she was 28 years old and was unemployed. 2) Miss JONES was found dead by her daughter at around 0800 hours at her home address of [redacted], Shanklin, Isle of Wight. She had a long history of mental health issues, including schizo-affective disorder, obsessive compulsive disorder and suicidal thoughts which included

	hearing voices telling her to kill herself. 3) She was prescribed Amisulpride (an antipsychotic drug), Clozapine (another antipsychotic drug) and Trazodone (an antidepressant and sedating drug). 4) The toxicology which was undertaken as part of the post-mortem examination revealed that the Clozapine was found at a level indicating high dose/chronic therapeutic use. This drug is used to reduce the risk of recurrent suicidal behaviour. At high dose, it can lead to a prolongation of the cardiac QT interval and lead to cardiac arrhythmia and hypotension. According to the toxicology report, there is an apparent overlap between the concentrations obtained in non-fatal overdoses and those observed in fatalities. 5) The evidence given by Megan's Consultant Psychiatrist was that the dose that Miss JONES was being prescribed of her two antipsychotic medications was 108% of the British National Formulary ("BNF") limit (with Clozapine at 58% and Amisulpride at 50% of the maximum recommended dose). The Consultant Psychiatrist indicated that where a patient is prescribed a combination antipsychotic regime and/or is being prescribed more than 100% of the BNF antipsychotic prescription, this situation requires greater vigilance by the treating clinicians due to the potential risk of cardiac arrhythmias – especially where a patient was abusing laxatives, which Miss JONES was known to be doing. 6) It is believed that Miss JONES suffered a fatal cardiac arrhythmia due to the higher than optimal recommended dose of her combined antipsychotic medications.
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. It is clear that there is no formal policy or protocol in place for GP's surgeries with regard to the monitoring of those patients who are prescribed Clozapine antipsychotic medication. 2. It would be relatively simple for the CCG to instigate such a policy or protocol that where a patient is prescribed Clozapine, they must be monitored on a regular basis to ensure that there is some form of QTc recording.

	3. This policy/protocol is especially important where the patient is prescribed more than 100% of the BNF limit of antipsychotic medication(s).
6	**ACTION SHOULD BE TAKEN** In my opinion 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, namely by 5th June 2019. 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: [redacted], the Isle of Wight NHS Trust. 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	 **H.M. Senior Coroner – Isle of Wight** **17th April 2019**