ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. [redacted] The Bexley Medical Group, 171 King Harold's Way, Bexleyheath DA7 5RB
1	**CORONER** I am Philip Barlow, assistant coroner, for the coroner area of Inner South London
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 27 September 2017 I commenced an investigation into the death of Feni Lee, age 34. The investigation concluded at the end of the inquest on 21 June 2019. The conclusion of the inquest was as follows: Medical Cause of Death: 1a) multi-organ failure 1b) colchicine overdose Feni Lee had Behcet's syndrome for which she was receiving repeat prescriptions of colchicine from her GP. In September 2017 she took an excessive quantity of colchicine over a two week period because she was feeling unwell. She developed severe side effects, including liver necrosis, and was admitted to Queen Elizabeth Hospital where she died on 17 September 2017. The narrative conclusion was that Feni Lee died after taking excess colchicine for Behcet's syndrome without intention of self harm.
4	**CIRCUMSTANCES OF THE DEATH** Up until January 2016 Feni Lee was being seen as an outpatient by [redacted], a specialist at Guys Hospital (Guys), for the management of Behcet's syndrome. As part of her treatment Ms Lee had been prescribed colchicine. Colchicine is an unlicensed but recognised treatment to control ulceration in Behcet's syndrome. Ms Lee failed to attend further appointments at Guys after January 2016 and so her last appointment at Guys was on 6 January 2016. Colchicine continued to be prescribed by Bexley Medical Group as a repeat prescription up until her death in September 2017.
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) You informed the inquest that Bexley Medical Group has a system whereby all

	medication obtained by repeat prescription is reviewed annually. You could not say exactly when the review of Ms Lee's medication took place (at that time it was not documented) but said it would have been towards the end of 2016. You said the review looked at the need for ongoing medication and the dose. There were a number of features that do not appear to have been taken into account at this review: a. Colchicine is an unlicensed usage of a drug used to treat a rare disorder. It was being prescribed by the GP under instructions from a specialist hospital clinic. b. There had been no instructions from Guys as to what should be prescribed since January 2016. c. The instructions from Guys in January 2016 do not mention colchicine. No inquiry was made with Guys to check whether the intention was for it to be continued as part of the treatment, and yet it continued to be given by the GP as a repeat prescription. d. The dosage being given on repeat prescription does not match any of the recent instructions from Guys about its use. e. Ms Lee had mental health problems and was a vulnerable person. I therefore have concerns about the thoroughness of this medication review. (2) Towards the end of 2016 it would have been obvious that Ms Lee had been lost to follow up at the hospital, and so the drug review appears to have been a lost opportunity to rectify this. (3) You informed the inquest that there are two GP practices at Erith Health Centre on Pier Rd. They are based in the same building and the receptionists from both practices work in close proximity. The letter from Guys relating to the outpatient clinic on 20 October 2015 was appropriately sent to Erith Health Centre on Pier Rd but had the name of a GP from the other practice. You accepted that there was considerable delay in this letter being forwarded to your practice and that it was scanned onto your system some 2 to 3 months after it was sent. You also accepted that it was placed onto your system without being seen or actioned by a GP. My concern is that there does not appear to be an effective means whereby post is re-directed between the two GP practices. I am therefore copying this report to the other GP practice, which I understand to be the practice of [redacted] and [redacted]
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your GP practice, Bexley Medical Group, 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 27 August 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: (1) Ms Lee's family, c/o Leigh Day solicitors (2) Oxleas NHS Trust

	I have also sent it to: (3) [redacted] and [redacted] Erith Health Centre, 50 Pier Rd, Erith, Kent DA8 1RQ (4) [redacted] consultant in oral medicine, Guys & St thomas' NHS Trust who may find it useful or of interest. 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	**28 June 2019** **Philip Barlow**

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (2)

*NOTE: This form is to be used **before** an inquest.*