Regulation 28: Prevention of Future Deaths report

Theresa Robertson (died 18/9/19)

THIS REPORT IS BEING SENT TO:

- **Dr [redacted] - Rush Green Medical Centre, 261 Dagenham Road, Romford, RM7 0XR**

CORONER

1 I am: Graeme Irvine. HM Area Coroner for East London, Walthamstow Coroners Court, 124 Queens Rd, Walthamstow, London E17 8QP

CORONER'S LEGAL POWERS

I make this report under the Coroners and Justice Act 2009,

2 paragraph 7, Schedule 5, and

The Coroners (Investigations) Regulations 2013,

regulations 28 and 29.

INVESTIGATION and INQUEST

3 On 19th September 2019, I commenced an investigation into the death of Theresa Robertson, The investigation concluded at the end of the inquest on 5th August 2020. I made a determination of Accidental Death. The medical cause of death was: 1a Amitriptyline and Zopiclone toxicity and hypothermia

CIRCUMSTANCES OF THE DEATH

4 Mrs Robertson was found on the evening of 18th September 2019 deceased outside of 90 Greengate Street, Plaistow, London E13 on railings behind a war memorial.

The deceased was captured on CCTV moving into that position on the afternoon of 16th September 2019. The footage shows her to be unseasonably dressed and disoriented.

A post-mortem examination and toxicological analysis of fluid samples demonstrated that Ms Robertson had a significant concentration of Amitriptyline and Zopiclone in her bloodstream. Each substance was detected at levels at least six times higher than the expected therapeutic level.

Ms Robertson had been prescribed both Amitriptyline and Zopiclone by her GP for a number of years. The prescriptions provided were for a month-long supply of the medications.

Evidence before the court indicates that Ms Robertson had taken deliberate overdoses of her prescribed medication on at least two prior occasions in 2018 and 2019.

On 22nd April 2019 Ms Robertson was admitted to hospital having taken an overdose of her prescribed medications. On 24th April 2019, [redacted], daughter of the deceased called the Rush Green Medical Centre and spoke to a receptionist regarding her mother. Later Dr [redacted] called [redacted] back. The Surgery accepts that the calls occurred, but no record of the calls was ever made. [redacted] asked Dr [redacted] to desist from providing her mother with 28 day prescriptions for her medications.

The deceased was discharged from hospital and a discharge notice was sent to Dr [redacted], explaining the circumstances of the overdose and advised a review of medications in the light of the risk of overdose.

On 29th April 2019, the surgery undertook a review of Ms Robertson's medication and halted the Zopiclone prescription.

On 30th April 2019, Ms Robertson attended the surgery for an emergency appointment with another GP at the Surgery, Dr [redacted]. Ms Robertson's 28 day prescriptions for Amitriptyline and Zopiclone were reinstated. No clear note of this consultation exists to provide an explanation why this decision was made.

Dr [redacted], on behalf of the surgery accepts, in hindsight, that this decision was in breach of the surgery protocol which requires limitations to be placed on the prescriptions of those patients with a confirmed risk of overdose. Dr [redacted] confirms that Ms Robertson should have only been offered a seven day prescription.

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.

5

1. The surgery admitted that no documentary record was taken of two critically important telephone calls between [redacted] and the surgery regarding the deceased.
2. On 30th April 2019 Dr [redacted] acted outwith the surgery guidance to allow high risk patients a prescription for medication for over 7 days in length.
3. The Surgery could not produce a meaningful record of Dr [redacted] consultation held with Ms Robertson on 30th April 2019 setting out the reasons for re-starting her 28 day prescription.
4. Dr [redacted] could not reassure the Court that any steps had been taken to audit the patient records to determine whether any other high risk patients were receiving prescriptions outside of the constraints of the surgery policy.

ACTION SHOULD BE TAKEN

6

In my opinion, action should be taken to prevent future deaths and I believe that your organisation has the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely
7 by 1st 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.

COPIES and PUBLICATION

8

I have sent a copy of my report to the following.

- The Robertson family.
- Newham Care Commissioning Group
- The Care Quality Commission for England

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.

DATE 6th August 2020 SIGNED BY AREA CORONER IRVINE