Mid Kent and Medway Coroners
Cantium House
2nd Floor
Maidstone
Kent
ME14 1XD

[redacted]

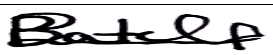
REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

Natalie Mortimer (died 21.04.2022)

	THIS REPORT IS BEING SENT TO: [redacted] GP Partner at Green Porch Medical Centre Green Porch Medical Centre
1.	**CORONER** I am Bina Patel, Area Coroner for the coroner area of Mid Kent & Medway.
2.	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3.	**INVESTIGATION and INQUEST** On 3rd May 2022 I commenced an investigation into the death of Natalie Mortimer who died, aged 27, on 21st April 2022 at St Thomas' Hospital, Lambeth Palace Road, London. The investigation concluded at the end of an inquest on 14th July 2022, conducted by me. I gave a narrative conclusion that:

	Natalie Mortimer died on the 21st April 2022 at St Thomas' Hospital, Lambeth Palace Road, London. She was transferred to the intensive team at St Thomas' Hospital from Medway Maritime Hospital after presenting there on the 16th April 2022 with abdominal pain, diarrhoea and vomiting following an overdose of [redacted] tablets on the 15th April 2022 prescribed to her for gout. She died from multiorgan failure caused by colchicine overdose. She had a previous overdose attempt in April 2021 prior to her death and a past medical history of anxiety and depression. The medical cause of death was: Ia. Multiorgan Failure Ib. Colchicine Overdose 1c II.
4.	**CIRCUMSTANCES OF THE DEATH** Natalie Mortimer died on the 21st April 2022 at St Thomas' Hospital, Lambeth Palace Road, London. She was transferred to the intensive team at St Thomas' Hospital from Medway Maritime Hospital after presenting there on the 16th April 2022 with abdominal pain, diarrhoea and vomiting following an overdose of colchicine tablets on the 15th April 2022 prescribed to her for gout. She died from multiorgan failure caused by colchicine overdose. She had a previous overdose attempt in April 2021 and a past medical history which included anxiety and depression.
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: Evidence was heard that: (1) The GP Practice received a discharge note from the hospital for a previous overdose attempt in April 2021. The patient's medical record was not updated to reflect this information.

	(2) On the 25th November 2021 the patient attended the GP Practice and the GP on duty reviewed her most recent consultation which took place on the 22nd November 2021 and her records and prescribed the patient with [redacted] to be taken 2-4 times a day until symptoms resolve for her gout. The GP detailed in evidence that she issued 100 tablets as this was the default quantity that came up on EMIS. The prescribing doctor stated that there were no alerts or coding of a previous overdose in the patients records which may have been a contraindication for issuing a prescription of 100 tablets and therefore relied on the default quantity generated by the system.
6.	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 **19th September 2022**. 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 following: • HHJ Thomas Teague QC, the Chief Coroner of England & Wales • [redacted] (Father) on behalf of the family of Natalie Mortimer I am 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.	Signature:

	 Bina Patel, Area Coroner, Mid Kent & Medway 25th July 2022