NHS
Norfolk and Suffolk
NHS Foundation Trust

**Trust Management**
Main Administration Block
Hellesdon Hospital
Drayton High Road
Norwich
NR6 5BE

Ms Jacqueline Lake
Norfolk Coroner's Service
County Hall
Martineau Lane
Norwich
NR1 2DH

17th November 2022

Dear Ms Lake

Regulations 28 and 29 (2013) notification made in response to the death of Lewis Begley.

I write to you in respect of Lewis Begley who died in December 2020. His inquest was held in September 2022, at the end of the inquest you raised concerns outlined in this response within a prevention of future deaths notification.

I would like to reiterate to you and importantly to Lewis's family our sincere regret and apologies for the death of Lewis whilst under our care.

The concerns you raised are outlined below with our trust response to each point:

**1. Evidence was heard that medication is kept in a locked room and in locked cabinets, in accordance with legislation. However, there is no record kept as to what medication is stored and how much, particularly [redacted] which is a drug subject to misuse, in a mental health hospital where many patients have a history of drug misuse and suicidal ideation and actively seek out the drugs cupboard.**
We have recently employed a new Chief Pharmacist in the trust who has already begun improvement work in this area her initial action plan includes:

- Medicines Management Policy to be revised, implemented and monitored across the trust.
- Safe and Secure Handling of medication audit will now be led by Pharmacy, this is a change in process and accountability and address the issues of stock oversight in ward areas.
- Audit action plan will be developed for each clinical area together with nursing and pharmacy team.
- Pharmacy to support Medicines Management Efficacy &Treatment at ward level.
- All staff complete Medicines Management training as Statutory and Mandatory training.

**2. On a patient accessing medication, there is no knowledge as to whether anything has been taken and if so, how much, thereby limiting knowledge as to what treatment is to be considered and what action to be taken**
As above.

**3. Evidence was heard that there is no fixed training given to doctors with regard to the administering of [redacted] in the event of there being a suspected drugs overdose**.

In line with other mental health trusts, we will continue to train staff and stock [redacted] as part of the resuscitation response adhering to the Resuscitation Council UK guidelines, both nurses and medics are able to administer this drug to reverse a suspected or known opiate overdose.

In respect of [redacted]l and in line again with other mental health trust we will continue to stock [redacted] as a potential antidote to a suspected or known [redacted] overdose; in case there is a medic available who is experienced and able to administer. However, we will not train our medics to administer this as the skill cannot be maintained without regular use. To note in our internal review the ambulance trust advised that the ambulance crews and paramedics do not administer this drug unless they have a specialist medic on the team for the same reason.

Please note the guidance below:

**BNF**

*"[redacted] should only be administered by, or under the direct supervision of, personnel experienced in its use.*

*Use of the [redacted] can be hazardous, particularly in mixed overdoses involving [redacted] antidepressants or in [redacted]-dependent patients. [redacted] may prevent the need for ventilation, particularly in patients with severe respiratory disorders; it should be used on expert advice only and not as a diagnostic test in patients with a reduced level of consciousness."*

**Maudsley Practice Guidelines for Physical Heath Conditions in Psychiatry by David Taylor et al**

*"[redacted] can be hazardous because of risks of precipitating seizures and ventricular arrythmias. It should only be used by people with previous experience of its use (or in the presence of people with experience)."*

*"In the UK it is only licensed for reversal of sedative effects of [redacted] in anaesthesia, other clinical procedures, or in intensive care. The main focus of managing suspected [redacted] overdose should be to resuscitate according to ABCDE approach and transfer care to emergency services."*

I hope that this response answers your concerns, the sad death of Lewis was not anticipated however we apologise that we did not have the robust systems in place at that time which would have enabled staff to ascertain what and how much medication he had acquired.

It is anticipated that in light of the Chief Pharmacists improvement plan our medication management systems will meet the necessary safety levels in the future providing confidence and resilience for all.

Yours sincerely

[redacted]

[redacted]
Chief Executive Officer