REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive Oxleas NHS Trust via emial [redacted] Chief Executive, NHS England- via email
1	**CORONER** I am Professor Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West 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** Between 26th February 2024 and 29th February 2024, evidence was heard before a jury touching the death of Mr Lee Martin Hughes, also known as Martin Lee Hughes. He had died on the 25th December 2021, aged 50 years whilst remanded in HMP Wandsworth. **Medical Cause of Death** 1 a Methadone and Benzodiazepine intoxication **How, when, where and in what circumstances the deceased came by his death:** Lee Martin Hughes was remanded to HMP Wandsworth on 18th December 2021. He was found deceased in his cell in HMP Wandsworth on 25th December 2021 at approx. 0500. On arrival, the nurse gave him a COWS score of 12 and a CIWA score of 12-13. He was familiar to the nurse based on previous visits and she noted him looking healthier than previously. • Mr Hughes reported drug use of [redacted] heroin /day; [redacted] cocaine; [redacted] diazepam tablets; cannabis. He also reported [redacted] alcohol/week. We consider this report to be unreliable based on other evidence we heard. • His urine test was positive for : opiates (not specifically heroin); cocaine; diazepam; cannabis. His urine was negative for methadone. • He was prescribed [redacted] diazepam twice daily, administered on 18th, 19th, and 20th; and methadone [redacted] on the 18th; and [redacted] 19th and 20th.

	• Based on a COWS score of 2 found on 19th December 2021 we understand that this medication was sufficient to control his signs of withdrawal.
	• On 20th December 2021, the Doctor increased his methadone prescription to [redacted] to be titrated up over the following days. Our understanding is this was reasonable and appropriate based on a COWs score of 7 and BNF guidance.
	• We believe this increase in methadone did contribute to his death, but does not equate to a failure in care.
	• He was declined an increase in methadone on 23rd December 2021. Our understanding is this was appropriate.
	• He showed signs of intoxication on 23rd December 2021 (nodding off).
	• We believe based on the evidence in hindsight it would have been appropriate to omit a dose of methadone on 23rd December 2021, despite confounding factors.
	• We found evidence of multiple events where Mr Hughes was unrousable on 24/12/2021, in order to administer diazepam.
	• Based on the evidence, we do not believe this was appropriately managed by healthcare.
	• We have seen insufficient evidence to believe he was seen awake or vaping on 24th December 2021 at 2100.
	• Based on the evidence, we understand his consciousness to have been impaired when he was visited by the nurse at c. 2110 on 24th December 2021.
	• Medical help should have been sought:
	  • Code Blue should have been called at 2110.
	  • Medical escalation to the HOTEL nurse when the medication could not be administered by the Pharm Tech at 18:10.
	  • Based on this evidence, we believe there a really serious (gross) failure to care for Mr Hughes, encompassing the behaviour of the nurse who entered the call at 21:10.
	  • Had care been sought, we believe Mr Hughes would have survived at this time.
	  • We believe this was a lost opportunity.
	  • We find the medical cause of death to be methadone and Benzodiazepine Intoxication.
	  • As a footnote, we believe Mr Hughes's knowledge of the system (drug seeking behaviours) contributed to his death.
	  • We note the lack of communication between disciplines in HMP Wandsworth was a contributing factor to Mr Hughes's death, specifically –
	  • Pharmacy techs not adequately escalating the reason that Mr Hughes could not be medicated, including the lack of real time and accessible written notes.
	  • The delay in trying to medicate Mr Hughes between the pharmacy techs alerting the day nurses for a second time at 18:10 and the night nurse first visiting Mr Hughes at 20:42.
	
	Conclusion of the Jury as to the death:
	
	Drug-related Misadventure contributed to by Neglect.

4	Extensive evidence was taken during the inquest from multiple live witnesses, written statements, and exhibited reports. Of relevance to this report in addition to the findings of the jury above, which I do not repeat: The independent expert instructed by the court in this case in this case raised multiple concerns: - That the GP who increased Mr Hughes's methadone on 20th December 2021, did this by applying guidelines without full consideration of evidence from others, for example his COWS score of 2 the previous day after [redacted] methadone, that Mr Hughes had slept, that the nurse who knew him felt he was not experiencing

withdrawal. Further, the assessment that this GP made relied largely upon subjective symptoms rather than objective signs to form a COWS score of 7 and increase the methadone to a level that proved ultimately fatal with the concurrent administration of benzodiazepines, rather than leaving Mr Hughes at the same dose and reviewing him.

- That no dose of methadone was omitted on 23rd December 2023 despite Mr Hughes nodding off in the consultation.
- That Mr Hughes would have been highly likely to have survived even if emergency help was requested at the last interaction at 21:10, and naloxone and other supportive care had been given.
- That tolerance to opiates can fall away completely within 3 to 4 days of lack of opiate use, increasing risks of death if for example methadone is started.
- That due the long half life of methadone that it takes 5 days of same dose prescribing before the level in the blood stream stabilises.
- That most deaths from methadone occur in the first two weeks of starting the drug. Mr Hughes died on day 7.

There was at that time, no reliable drug testing for illicit drugs, especially SPICE, available for near patient testing.

That one reason for prescribing cited by the doctors was to mitigate the drive for the inmate to use illicit drugs, which have their own dangers.

Evidence was taken that illicit drugs are widely available in HMP Wandsworth, however the toxicology findings were consistent with him having died solely from methadone and diazepam as prescribed.

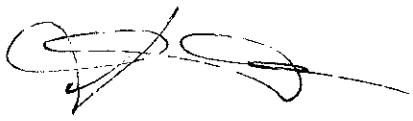
Other evidence was that the pharmacy technicians had no training in consciousness assessment and did not record their interactions on the medical records (System One).

Since Mr Hughes's death an SI was undertaken and many lessons were learned and procedures changed within Wandsworth, including the following matters:

- Pharmacy technicians have been trained as to how to assess consciousness and the risks of sedative drugs especially when given in combination.
- That emergency medical assistance should be sought when an inmate shows signs of impaired consciousness.
- That pharmacy technicians should record their patient/inmate interactions on System One.
- That this case has raised awareness across the prison estate of dangers of methadone, especially when prescribed alongside benzodiazepines or other sedatives, prescribed or illicit drugs.
- That all prescribing for those inmates that require pharmaceutical intervention for withdrawal is undertaken by the Substance Misuse Team.
- That the use of objective assessment to assess withdrawal signs is emphasised.
- That on commencing methadone consideration is given to the time spent in custody before remand in prison as to how much methadone should be prescribed in view of the risks of decreasing tolerance to cardiorespiratory effects that may have taken place whilst in custody when prescribing methadone.
- That especial consideration should be given when methadone is prescribed in combination with other sedative drugs.
- That policies reiterate that methadone should be withheld if patient/inmate is showing signs of intoxication.
- That there is better availability of near patient testing for illicit drugs, including SPICE.

Much of this is clearly good practice and there would be benefits if these changes and improvements in practice were adopted across the prison estate.

	To this end, this report has also been sent to NHS England, so that the lessons learned from this death may be applied to all prison health care services.
5	**Matters of Concern** 1. That clinicians, wishing to believe their patients, are relying too heavily on what patients tell them (symptoms) rather than looking for evidence (physical signs) of withdrawal, As such, given the particular difficulties of prescribing to prisoners, that objective signs of withdrawal assessments (OWS) should be used to determine whether methadone should be prescribed rather than the COWS score which contains many subjective factors and may be more easily manipulated by an inmate to appear as if that inmate is experiencing withdrawal from drugs necessitating an increase in methadone. 2. That prescribing of drug treatments for withdrawal should only be undertaken by substance misuse practitioners, who should therefore be more experienced as to when, whether and how much to prescribe. 3. That guidelines are followed without sufficient consideration as to whether they apply to the individual patient. 4. That practitioners when prescribing consider whether time spent in custody prior to remand may have reduced an individual's tolerance to opiates, especially when methadone is to be prescribed with a synergistic agent such as a benzodiazepine. 5. That methadone should be withheld and or reduced if the patient/inmate is showing signs of sedation. 6. That there should be tests available for illicit drugs for near patient testing to allow a clinician to better assess a patient showing signs of intoxication.
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. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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:

	Sister of Mr Hughes : [redacted] Governor, HMP Wandsworth, Heathfield Road, Wandsworth, London. Sw18 3HU. [redacted], Investigator, PPO, Third Floor, 10, South Colonnade, Canary Wharf, London. E14 4PU. 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	**4th March 2024.**  **Professor Fiona J Wilcox** **HM Senior Coroner Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED** **Inner West London Coroner's Court,** **33, Tachbrook Street,** **London.** **SW1V 2JR** **Telephone:0207 641 8789.**