REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], **Chief Executive, Norfolk and Suffolk NHS Foundation Trust,**
1	**CORONER** I am Nigel Parsley, Area Coroner, for the coroner area of Suffolk.
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 15th May 2017 I commenced an investigation into the death of Rachel Holly Edwards. The investigation concluded at the end of the inquest on 22nd February 2018. The conclusion of the inquest was that; Rachel Edwards died as the result of an overdose of her prescription medicines following a seven-year period of suffering from severe and unbearable pain, the result of injuries sustained in a fall from height in 2009. The medical cause of death was confirmed as: 1(a) Over dose of multiple drugs.
4	**CIRCUMSTANCES OF THE DEATH** Rachel died on the 8th May 2017as the result of an over dose of multiple prescription medicines at her home address [redacted], Suffolk. A concerned friend had been unable to contact her when visiting Rachel's home and had called her family. Rachel's father Chris arrived at a short while later with a spare key to the property, entered and subsequently found his daughter fully clothed but unresponsive in the bath. The emergency services were called and upon arrival of a paramedic Rachel's death was recognised at 08.39 on the 8th May 2017.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you; the **MATTERS OF CONCERN** as follows:- Prior to Rachel's death, on the 6th March 2017 she was informally admitted to the Woodlands mental health ward in Ipswich following a significant overdose she had taken on the 3rd March 2017.

Rachel told the admitting doctor that the overdose consisted of [redacted] tablets of various types of medication taken impulsively due to ongoing pain, lack of sleep and being discharged from a pain clinic that had offered hope of a trial surgical implant to manage her pain.

It is clear from the evidence presented that Rachel's low mood and feeling of 'hopelessness' was directly linked to the constant pain she was suffering. Witnesses also described that Rachel's low mood and feelings of hopelessness were compounded when she received negative news regarding her pain management. This was not isolated to the incident noted above but was a feature of Rachel's presentation known by her family, care co-ordinator and treating mental health care professionals.

Rachel was discharged from Woodlands on the 29th March 2017. Evidence was put forward regarding Rachel's (and her family's) belief she was being discharged too soon and would not be safe at home. This evidence was considered in depth and based on that evidence Rachel's actual discharge date is not the subject of this report to prevent future deaths.

However, two issues of concern surrounding Rachel's discharge and her subsequent treatment in the community were identified during the inquest.

The first concern regards the prescription of discharge medication, sharing that information with the GP and record keeping.

It was known that Rachel was at risk of stockpiling medication as in the Serious Incident Requiring Investigation (SIRI) report it is noted that a request made on the 7th March 2017 by her treating doctor, for the disposal of her stocks of medication had not been actioned.

Further, Rachel's care co-ordinator specifically recalled asking Rachel if she had stockpiled any medication after her discharge on the 29th March 2017, as he had identified this to be a risk.

It is therefore a concern that according to Rachel's notes that on the day of her discharge she was supplied with 14 days of medication. This was described in evidence as 'standard practice'.

That said, some consideration appears to have been given to the quantity of some medication issued, as on closer inspection of the notes it was identified that specifically in relation to Tramadol Rachel had been prescribed this for only a 7-day period.

However, there was no clear record within the notes if her other medication had actually been issued in 7 or 14 days amounts.

Such confusion over the actual quantities of medication issued and the apparent issuing of 14 days supply of medicines to a patient who is known to have previously stockpiled medication, with a view to self-harm, is of obvious concern.

Also of concern was evidence given by a senior consultant that there is no automated notification to a patient's GP of the type and amounts of prescription medicines issued to a patient upon discharge from Woodlands. Obviously, it is crucial that this information is readily available to a GP in all cases, to ensure that the over-prescription of medicines to a recently discharged patient does not occur. Evidence was heard that in order for Woodlands to notify a GP it is necessary for a staff member to e-mail the relevant practice, providing details of the prescriptions that had been made. This information would then have to be subsequently included in the patient's local record before it was available to the treating GP. Obviously, any system

	requiring such physical human input can be prone to failure and in the consultant's own words it was a recognised 'point of weakness in the system' Secondly, it was a known that the arrival of disappointing news regarding her pain management treatment was a clear stressor to Rachel and that such news significantly increased her sense of hopelessness. Despite this being known there was no 'patient advocate' or other similar service in place to act as filter and alert those providing support to prepare for the increased feeling of hopelessness that would clearly follow such news. Further, dealing with the large quantity of correspondence generated by her various treatment regimes and trying to de-conflict and re-schedule multiple appointments also left Rachel feeling overwhelmed, again adding to her sense of hopelessness. Again, no effective patient advocate system was in place to support her with this. During the inquest an example of the good use of a 'patient advocate' scheme was heard, but this advocate was in place by virtue of the initiative of a local mental health practitioner. As such it was identified that although a 'patient advocate' could provide the support needed when appropriate, there is no formal system in place for an advocate to be appointed in other cases when it could prove beneficial.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 24th April 2018. I, the Area Coroner, may extend the period if I consider it reasonable to do so. 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 Person, [redacted] 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 Area Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**27th February 2017** **Nigel Parsley**