Improving together
Safer • Kinder • Better

Norfolk and Suffolk
NHS Foundation Trust

NSFT Trust Management
Norfolk & Suffolk NHS Foundation Trust
Floor 7
County Hall
Martineau Lane
Norwich
NR1 2DH

Tel: 01603 421421

Date: 17th January 2025

Senior Coroner, Nigel Parsley
Suffolk Coroner's Court
Beacon House
Whitehouse Road
Ipswich
IP1 5PB
Email: [redacted]
By email only

Dear Senior Coroner Parsley

Regulations 28 and 29 (coroners investigations regulations 2013) notification made in response to the death of Amy Butcher

I write in response to the Regulation 28 report made on 26th November 2024 in respect of concerns raised at the inquest touching the sad death of Amy Butcher which concluded on 1st November 2024.

I have reviewed the report in its entirety and provide responses below each summarised concern for ease of reference.

1. ***There is evidently no single point of contact, or single decision maker regarding prescriptions in cases like Amy's, which is exacerbated further out of hours;***

   I can confirm that the NHS 111 Mental Health Option telephone support line operated by NSFT is not commissioned to provide medication prescriptions.

   I recognise that Amy interacted with multiple prescribing pathways within the NHS system and whilst NSFT is not the responsible commissioner for NHS 111 Option 1, GP surgeries or out of hours GP services we have raised the issue with our Integrated Commissioning Boards with a view to identifying any possible improvements that can be made as a result of the concern raised.

   Prescribing pathways within NSFT are set out in our Management of Medicines Policy and includes inpatient, outpatient and Crisis Resolution and Home Treatment teams 'CRHT'.

   Crisis Resolution & Home Treatment teams have three prescribing options available:
   - (i) FP10s which should be avoided where possible as it relies upon a service user to source the required medication from a pharmacy directly;
   - (ii) Electronic Patient Medication Administration (EPMA) system. Medications are dispensed from the Trust's central pharmacy at Hellesdon Hospital, Norwich, to satellite bases around the county, this means there is variation in the delivery timeframe. Option 3 is designed to help mitigate this.
   - (iii) Each CRHT base has a limited stock of various of pre-packed medications which can be provided to service users. The amount included in the pre-packed medications is a 3-day supply.

   I note in the NSFT staff evidence they had requested Amy to ask the GP for a further prescription and increase of her antidepressant medication which was prescribed by the GP prior to referral to CRHT. The clinical rationale for this was to reduce the risk of medication errors, however, while the intention of this is to provide safe care, in circumstances where a patient may be distressed, and there is a risk of

non-adherence, best practice would have been for the CRHT staff to have contacted the GP directly to make this request.

Further, I noted the GP's evidence in respect of the complexity of prescribing mental health medications.

To simplify the position, we have added the following information to our standard letters which are sent to GPs when service users are taken onto CRHT caseloads:

Your patient has been accepted for treatment under the Crisis Resolution & Home Treatment team.

Please continue to prescribe all physical health medications and advise CRHT in the event that you make changes. We will advise you if we need you to review physical health medications as a result of any prescriptions we commence.

Please continue to prescribe all mental health medications that were prescribed at the point of referral unless we advise you otherwise.

This information will provide clarity for both GPs and CRHT teams and means that GPs can confidently continue to prescribe all medications they had been prescribing prior to CRHT involvement and CRHT can make prescribing decisions with the knowledge of which medications GPs are already prescribing.

Staff have been reminded of the need to liaise directly with GPs with any requests to adjust medications already prescribed by GPs in the circumstances described above.

By way of assurance, the clinical audit team will undertake a joint audit with primary care colleagues 3 months post implementation of the above wording being introduced, the results of which will be reported to our Trust wide Safety Group for consideration.

2. ***A lack of knowledge in relation to the common usage of microdose hallucinogenic mushrooms as a self-treatment by mental health patients, a lack of knowledge in relation to there being no contraindications for the prescription of Lorazepam if micro dose hallucinogenic mushrooms were being used, and defining Amy as 'non-concordant' due to her use of Zopiclone when her PRN medication proved ineffective, prevented a realistic opportunity for the MDT to consider if Lorazepam should have been prescribed to Amy***

I note your record of the evidence given by the A&E Consultant was that they could only prescribe Lorazepam on discharge if the mental health team requested this. Upon enquiring further, I understand that the agreed process with our acute hospital colleagues is that where a patient has been deemed medically fit for discharge, subject to mental health assessment, the A&E Consultant would have no further involvement unless the mental health liaison staff specifically requested prescription of medication and it is in that context that the A&E Consultant would only prescribe on discharge if the mental health team requested it. It therefore remains open to an A&E Consultant to prescribe without reference to the mental health team if it is their clinical view that the same is necessary.

In this case, the mental health liaison team had access to the clinical records of the CRHT and as a result made the clinical decision not to request any further prescription of Lorazepam.

However, we know we can always improve our communication and services with our acute hospital colleagues and as a result we have recently implemented a new Standard Operating Procedure for our mental health liaison teams within the acute hospitals in Norfolk & Waveney. This documents clearly outlines the aims, objectives and expectations of our mental health liaison services within acute hospital settings. A copy of this document is enclosed for your information.

I note that the A&E Consultant gave evidence regarding prescription of Lorazepam where micro-dosing of hallucinogenic mushrooms was known was generally not a barrier, there was no contra-indication, and it

was often prescribed to reduce the hallucinogenic effects. However, the evidence of the A&E Consultant must be considered in the context of prescribing in a controlled ward environment as opposed to CRHT staff potentially prescribing in the community.

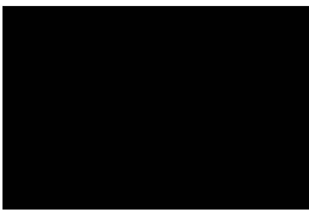
Our Chief Pharmacist office has advised that the British National Formulary does not, as a standard, list illegal substances as contra-indications.

Our Chief Pharmacist's office has undertaken a search of available studies/evidence to guide clinicians in this area and has found it to be extremely limited, with no specific studies related to benzodiazepines/lorazepam. We have also liaised with our drug and alcohol service system partners in Norfolk and Suffolk and our system colleagues did not have any specific guidance in respect of the same.

Our clinicians will adhere to their professional codes, national and regulatory guidance in conjunction with the Trust's Management of Medication Policy.

However, we remain committed to providing our services based upon best available medical evidence and we will continue to monitor the developments in this area for implementation in accordance with NICE or other regulatory guidance in the future.

Yours sincerely,



Chief Executive Officer