Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **Secretary of State for Department of Health & Social Care** **The Chief Executive of Norfolk and Suffolk NHS Foundation Trust**
1	**CORONER** I am Nigel PARSLEY, HM Senior 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 19th May 2023 I commenced an investigation into the death of **Amy Jade BUTCHER** The investigation concluded at the end of the inquest on 1st November 2024. The conclusion of the inquest was that the death was the result of:- **Suicide as the result of a deterioration in her mental health, exacerbated by an ineffective PRN medication prescription which failed to resolve her heightened anxiety crisis when needed.** The medical cause of death was confirmed as: **1a Fatal Pressure on Neck**
4	**CIRCUMSTANCES OF THE DEATH** **Amy Butcher was declared deceased at 07:26 hours on the 14th May 2023 at [redacted] in Suffolk.** **Amy had been found inside the premises, [redacted].** **Amy was being treated by Mental Health services and had four days earlier (10th May 2024) been admitted to A&E in a heightened anxiety crisis and wanting to die. At this time Amy was given Lorazepam (a 'pro re nata' [PRN] 'take as needed' medication). This medication was very effective for her, and once her anxiety crisis had passed, she was allowed home.** **Following her discharge Amy had consultations with her mental health crisis team and her GP, and made repeated requests for a prescription of Lorazepam, to take as a PRN medicine, if she suffered a further heightened anxiety crisis.** **Taking a PRN medication was one of the steps identified in Amy's agreed crisis plan.**

	Amy's request for Lorazepam was declined, and alternative PRN medications where subsequently prescribed. **On the evening of the 13th May 2024 Amy was particularly distressed, and it took her partner hours to calm her down, until Amy finally fell asleep.** **At some point Amy had taken her prescribed PRN medication (as evidenced in subsequent toxicology analysis), but in the early hours of the 14th May 2023, Amy awoke and suspended herself with a ligature around her neck.** **Amy's prescribed PRN medication had therefore not alleviated her heightened anxiety crisis.** **Had Amy had access to Lorazepam as a PRN medication on the evening of the 13th May 2023 (knowing the positive outcome this had for her on the 10th May 2023), it is more likely than not, that her death would not have occurred.** **Notes written by Amy, and disclosed to the Mental Health on the 8th May 2023, addressed to her loved ones, indicate that she premediated thoughts about taking her life, and therefore intended her death.**
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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** are as follows: (brief summary of matters of concern) **1. Evidence heard at inquest identified a muddled and unclear system for the prescription of medication to someone in Amy's situation.** **The Emergency Department Consultant who saw Amy in crisis on the 10th May 2024 stated that for patients like Amy she had previously prescribed Lorazepam upon discharge home, but could only do this if the Mental Health Team in the ED requested her to do so, which they did not do on this occasion.** **The following day, Amy herself tried to obtain a prescription of Lorazepam by dialling NHS 111 Option 2 (Mental Health line). She spoke to a mental health practitioner who told her that NHS 111 Option 2 did not have the ability to prescribe medication, and she would need to call NHS 111 Option 1 and speak to an Out of Hours GP instead.** **Amy contacted NHS 111 Option 1 and spoke to an Out of Hours GP, who worked for a private company which had implemented a ban on the prescription of Lorazepam due to its highly addictive properties.** **As such, even if the GP had considered Lorazepam to be required in Amy's case, he could not have prescribed it. The GP prescribed different PRN medications, which were subsequently found in Amy's system after her death.** **Amy's own GP gave evidence stating that the system for prescribing mental health medication was confusing. He stated that mental health medications prescribed to a patient by a GP (such as antidepressants) before a Mental Health Team became involved, remained the responsibility of the GP.**

However, once a Mental Health Team became involved, any changes to the medication regime could only be made by the Mental Health Team.

In addition, some medication would be prescribed by the Mental Health Team directly, whilst other would be prescribed separately by the GP.

The GP described the situation as one of there simply being 'too many chiefs'.

The net effect of the current system in place is that an individual in Amy's situation finds themselves needing to make multiple telephone calls or contacts with NHS 111 Option 1, NHS 111 Option 2, their Out of Hours GP Service, their own GP and their Mental Health Team, in order to try and obtain either a new prescription or change their current prescription if their mental health suddenly deteriorates.

There is evidently no single point of contact, or single decision maker regarding prescriptions in these cases.

The evidence suggests that the situation is exacerbated even further if the individual's mental health deterioration occurs Out of Hours.

2. **Evidence was heard that a decision had been made by the Mental Health Multi-Disciplinary Team that Lorazepam was not to be prescribed to Amy in any event. The court heard that Lorazepam was highly addictive and the subject of frequent misuse by individuals to whom it was prescribed.**

   There were two reasons given for the MDT decision.

   Firstly, Amy had volunteered to the Mental Health Team, that she had previously purchased online a 'micro dose of hallucinogenic mushrooms' to try and alleviate her systems. The court heard that like 'homeopathic medication' only a tiny amount of the active hallucinogen found in mushrooms would have been present, but that it was still illegal to possess this in the UK. Amy had told the team that she had only used this once.

   The MDT decision was that because this was an illegal drug, because the MDT were unaware that micro dosing of hallucinogenic mushrooms was being used by mental health patients, and because they did not know how it would react with the Lorazepam, no Lorazepam was to be prescribed to Amy.

   Secondly, Amy had previously disposed of medications prescribed to her which made her feel worse (a known side effect of some medications in the first few days of taking them). When advised to restart them, repeat prescriptions had to be made.

   In addition, just prior to her death Amy volunteered that she had been taking a sleeping tablet (Zopiclone) in the mornings, as well as taking them when she was supposed to at night. Amy had said that her current PRN medication had no effect, but the Zopiclone did help.

   As a result, it was recorded by the MDT that Amy was 'non-concordant' with her medication regime, therefore making her a higher risk of prescription misuse.

   However, in her evidence, the Emergency Department Consultant said she was fully aware of the fact that micro dosing of hallucinogenic mushrooms was being used by mental health patients, and that due to the tiny amount

	of active hallucinogen it was generally not a barrier to the prescription of any other medication. In addition, the Emergency Department Consultant stated that if an individual had ingested a toxic quantity of hallucinogenic mushrooms, there was no contra-indication for the prescription of Lorazepam as it was often prescribed to reduce the hallucinogenic effects. **In the evidence heard from members of the MDT, it was clear that the illegal use of a 'micro dose of hallucinogenic mushrooms' coupled with Amy's non-concordance, led to the decision not to prescribe her Lorazepam.** **As such, a lack of knowledge in relation to the common usage of micro dose hallucinogenic mushrooms as a self-treatment by mental health patients, a lack of knowledge in relation to there being no contra-indications 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.**
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by January 21, 2025. I, the Senior 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: **Amy's next of kin** 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. She may send a copy of this report to any person who she believes may find it useful or of interest. You may make representations to me, the Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Dated: 26/11/2024**  **Nigel PARSLEY** **HM Senior Coroner for** **Suffolk**