IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Tammy Denise Milward
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive Surrey and Borders Partnership NHS Foundation Trust 18 Mole Business Park Leatherhead Surrey KT22 7AD [redacted] Esher Green Surgery Esher Green Drive Esher Surrey KT10 8BX
2	**CORONER** Ms Susan Ridge, H.M. Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.

4	**INQUEST** An inquest into Ms Milward's death was opened on 14 March 2024. The inquest was resumed on 13 December 2024 and concluded on 20 December 2024. The medical cause of Ms Milward's death was: 1a. Mixed Drug Toxicity With respect to where, when and how Ms Milward came by her death it was recorded at Box 3 of the Record of Inquest as follows: > Tammy Denise MILWARD was found unresponsive by police following concerns for her welfare at her home in Esher Surrey on 1 January 2024. Her death was formally recorded by paramedics at 21:34 hours the same day. She had been prescribed [redacted] and toxicology revealed a potentially fatal concentration of [redacted], in excess of prescribed levels, in her blood sample and that she had also used cocaine shortly before her death. As a result, Ms Milward died of the effects of mixed drug toxicity. The inquest concluded with a short form conclusion of 'Drug Related':

5	**CIRCUMSTANCES OF THE DEATH** Ms Milward had a history of mental health problems including severe obsessive compulsive disorder. She was prescribed [redacted] and diazepam by her GP to help her deal with pain following a road traffic collision in approximately 2012. She had become dependent on her medication. On the advice of her GP, she wanted to reduce prescription levels, but she found this difficult to achieve and on occasions Ms Milward used her prescribed medication too quickly and had to request more through her GP. This caused her distress, and she would self-harm, or threaten self-harm. Towards the latter part of 2023, the GP practice referred Ms Milward to Surrey and Borders NHS Foundation Trust on several occasions for mental health support. As a result advice was provided by I-Access and she was referred to GP Integrated Mental Health Service (GPimhs). On 28 December 2023, Ms Milward sent an email message asking to be discharged from the GPimhs. In that email she accused her GPs of leaving her without medication and that "they are the reason for everything that happens next". GPimhs did not contact Ms Milward about her message and she was discharged from their service the next day. Separately on the 28 December 2023 Ms Milward's pharmacy contacted her GP practice and told them she wanted her prescription and had threatened self-harm. The practice spoke to Ms Milward and then the GP left a message for Ms Milward confirming the prescription had been authorised and providing her with crisis numbers. The GP was unaware that GPimhs had received a message from Ms Milward and GPimhs was not aware of the welfare concern raised by the pharmacy. Ms Milward phoned her mother in the early morning of 1 January 2024 and talked about going shopping. But later that day concerns were raised about her wellbeing and police conducted a welfare check and found her unresponsive. Toxicology revealed that she had used a significant amount of [redacted] as well as cocaine shortly before her death.

6	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are: The Inquest heard evidence that Ms Milward's case presented treatment challenges which several agencies sought to address but there was limited coordination, in particular that: a. The Coroner heard that the GP could not see GPimhs medical records (or any SABP notes) which are recorded on SystmOne and that GPimhs could not easily access the GP medical records held on EMIS. As a result, neither the GP practice, nor GPimhs was aware that the other had received messages from or about Ms Milward on 28 December 2023. The coroner heard from SABP that there is ongoing work ongoing to create greater connectivity between the various electronic record systems, but this work is not yet complete. b. The evidence heard suggests that there was little personal or practical interaction between the GP practice and GPimhs. The coroner was told that GPimhs had been recently introduced by SABP to work alongside GPs (addressing a need in primary care to provide mental health support) but that levels of interaction varied and was sometimes also undermined by a lack of suitable estate for co-location of GPimhs staff in GP practices. The coroner is concerned that the lack of coordination and communication between primary and secondary care providers may place patients at risk of early death.
7	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
8	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.

9	**COPIES** I have sent a copy of this report to the following: 1. Chief Coroner 2. Ms Milward's family 3. Surrey Adult Social Care 4. NHS Surrey Heartlands Integrated Care Board and Integrated Care System
10	**Signed:** **Susan Ridge** **H.M Assistant Coroner for Surrey** **Dated this 15 day of January 2025**