REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mid and South Essex Integrated Care Board** **Department of Health and Social Care** **NHS England & NHS Improvement**
1	**CORONER** I am Sean Horstead, Area Coroner, for the coroner area of Essex
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 8th September 2023 I commenced an investigation into the death of Michael Paul Barry aged 46 years. The investigation concluded at the end of the inquest on the 30th May 2025. Mr Barry died at Broomfield Hospital, Court Road, Chelmsford, Essex from a confirmed medical cause of death, following Post Mortem examination, of *'Ia Pneumonia'* and, under Part II (as having contributed to the death but not a direct cause): *'Excessive use of Codeine'.* I provided a Narrative Conclusion confirming that the deceased died, despite optimal medical care following admission to Hospital, from fatal complications of a community acquired pneumonia on a background of excessive use of Codeine medication. Notwithstanding evidence of the deceased's history of mental health issues and previous suicidal ideation, and an attempt to take his own life by way of overdose some three months prior to his death, the evidence did not disclose to the requisite standard of proof the deceased's intent at the time of taking excessive codeine medication in the period prior to his last hospitalisation.
4	**CIRCUMSTANCES OF THE DEATH**

	The deceased had a long-standing history of mental health problems and illicit drug and alcohol misuse. By the time of his death Mr Barry's use of illicit drugs had significantly diminished (though he continued to 'binge drink' to excess). However, he had developed a long-standing dependency on prescribed opiate based pain-killing medication following significant surgery some years prior to his death. Whilst the evidence did not disclose the source of the codeine taken in excess prior to his death, the evidence positively confirmed that, absent concomitantly raised paracetamol levels, the codeine identified in the toxicological analysis was likely *not* from the medication prescribed by the deceased's GP Practice. Accordingly, no direct causative link could be found, to the requisite standard of proof, between the prescribed medication itself and the death and, further, no finding or determination was made that was critical of the GP's on-going prescribing of the pain-killing medication. However, the lack of specialist support to which the GP could refer the patient was a significant concern.
5	**CORONER'S CONCERNS** During the inquest the evidence revealed matters giving rise to concern and in my opinion, there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – Notwithstanding the positive finding that the specific medication prescribed by Mr Barry's GP had *not* been the source of the excessive codeine taken prior to admission to hospital, compelling evidence was received at the inquest from a Partner at the GP Practice (with a particular specialism in this area of dependency-forming medications) that there remains *no specialist commissioned service available for GPs to which they might refer their patients to manage reduction of their intake of prescribed dependency-forming medications*. This is in contrast to the availability of commissioned services for patients who are dependent on illicit drugs and/or alcohol. The evidence confirmed that reduction or cessation of dependency-forming medications needs to be very carefully managed due to the risk of withdrawal symptoms and, in the context of the unchallenged evidence received, requires specialist input and training to maximise the prospects of success and to avoid potentially fatal consequences. The evidence, again unchallenged, was that the continuing absence of such a commissioned service gives rise to the risk of avoidable future deaths.

	The long-standing and continuing lack of commissioned services in primary or secondary care for assisting people to safely reduce and withdraw from such prescribed medication was confirmed in her evidence by the Director of Pharmacy and Medicines Optimisation within the Mid and South Essex Integrated Care Board (the ICB). This witness helpfully set out important steps currently proposed and/or being taken to educate clinicians and service users alike of the dangers of opiate based prescription medications (alongside their relatively limited benefits in most, though not all, cases) with a view to reducing the size of the cohort of patients at risk of becoming dependent/addicted in the medium and longer term. However, this does not - absent a commissioned service to which GPs and patients may turn for specialist advice and assistance - address the *immediate and on-going* risk of future deaths to those currently dependant on/addicted to these medications, with the numbers of such patients having significantly increased in the post-COVID 19 period as a consequence of lengthy delays to, for example, chronic pain-relieving surgery. Precisely this issue was highlighted in a previous PFD Report from 14th November 2019 issued by the former Senior Coroner in this jurisdiction. The response from the (then) Clinical Commissioning Group had indicated an intention to roll-out a *Prescribed Opioid Dependence Local Enhanced Service* in early 2020, but this was not implemented due to the COVID 19 pandemic. Since then, including at the date of Mr Barry's death in November 2023 and through to today, there remains no such, or similar, commissioned service across Essex or, it appears, consistently across England and Wales with only rare pockets around the country where such a service is commissioned.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 Thursday August 7th 2025. 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 and others: **The Family of the Deceased** **Essex Partnership NHS Foundation Trust** **Fern House Surgery** 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	 **HM Area Coroner for Essex Sean Horstead** **12.06.2025**