REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1) Secretary of State for Health and Social Care** **2) NHS England**
1	**CORONER** I am Brendan Joseph Allen, Area Coroner, for the Coroner Area of Dorset
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 the 29th April 2025, an investigation was commenced into the death of Isabelle Bridie Sapherson-Moralee, born on the 4th July 2002. The investigation concluded at the end of the Inquest on the 4th June 2026. The Medical Cause of Death was: 1a Respiratory depression 1b Combined severe morphine and gabapentin toxicity 1c 2 Bilary sepsis due to severe ketamine-related chronic liver disease The conclusion of the Inquest recorded that Isabelle Bridie Sperson-Moralee's death was due to misadventure.
4	**CIRCUMSTANCES OF THE DEATH** Isabelle started using ketamine in around 2020 and her use subsequently increased over the following years. For Isabelle, long term sustained use of ketamine led to a number of medical conditions including ketamine bladder

	syndrome, chronic liver disease and chronic pain. Ketamine bladder syndrome is known to be an extremely painful condition, as it was for Isabelle. Isabelle had also become doubly incontinent and was significantly underweight, which was again caused by her chronic ketamine use. Although Isabelle was engaged with a local drug treatment agency and in regular consultation with her GP, she was unable to maintain sustained abstinence from ketamine use: she was even found to be using ketamine during a hospital admission shortly before her death. Isabelle was prescribed morphine and gabapentin for pain relief. There was no evidence that she misused her medication. However, it seems likely that on the day of her death, with the intention of relieving her pain, Isabelle took too much medication, which, on a background biliary sepsis caused by severe ketamine-related chronic liver disease, caused her death. Isabelle was found deceased in her bedroom with the medication on the bed with her.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: 1. During the inquest evidence was heard that: i. Although there was engagement between local drug treatment services and Isabelle's GP, the evidence was this is rare, despite it being recognised that a multi-agency approach to ketamine addiction, given its significant negative health outcomes, is effective in co-ordinating services and the care of patients suffering with ketamine addiction. In the year prior to her death, Isabelle was referred to the Pain Management Team, was under the care of gastroenterologists during a hospital admission and was referred to the Eating Disorders Team and the Community Mental Health Team and was a service user of the local drug treatment service. There was no co-ordinated review of the care Isabelle required that involved all of the agencies/specialisms to

which she had been referred. Evidence was heard that there are no national policies and processes that address ketamine addiction and ketamine-related health conditions, with no recognised pathway that brings together the specialisms required to treat patients suffering ketamine addiction and ketamine-associated harms. A lack of a co-ordinated approach to care risks patients "falling through the cracks", with their addiction and associated medical conditions not being adequately addressed, and a consequent risk of death from the consequences of ketamine use.

ii. Isabelle was prescribed morphine for pain relief. There were difficulties in her prescribing due to concerns relating to concurrent ketamine use and the potential interactions of the drugs. I heard there are no guidelines available to those in primary care to assist with safe prescribing where ketamine use remains a concern. Safe prescribing guidelines can also assist patients in understanding the potential harms associated with the combination of prescribed medications and illicit ketamine, potentially reducing the risk of unintended overdose.

iii. There is limited research on the addictiveness of ketamine and the consequences of chronic ketamine use. It is noted that this aligns with the findings of the Advisory Council for the Misuse of Drugs (ACMD) in their report of 28th January 2026, which recommends that "ketamine should be included in the data collected by medical services about drug use, including ambulance services, emergency departments and hospital admission statistics". Such research and data collection will likely identify the prevalence of ketamine use and associated harms, informing the need for resources to be made available to address the risks and the harms associated with ketamine use.

2. I have concerns with regard to the following:

	i. There is no national treatment pathway for patients suffering ketamine addiction and ketamine associated harms that co-ordinates the specialisms that are required, despite the evidence that ketamine use has increased and that ketamine-related harms are being seen more frequently (though, as noted below, the full extent of this is unclear). ii. There are no prescribing guidelines to assist those in primary care who are prescribing analgesia for patients suffering ketamine bladder syndrome where there are concerns about concurrent ketamine use. The absence of guidelines presents a challenging scenario for both prescribers and patients. iii. A lack of research into the addictiveness of ketamine and the collating of the data relating to ketamine-related harms means there is currently no detailed understanding of the consequences of chronic ketamine use, no national processes to assist in developing effective care plans to break the cycle of addiction and no clear understanding of the scale of the health consequences ketamine use presents.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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, by 13th August 2026. 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: (1) Rothera Bray Solicitors (representing Isabelle's family) (2) DAC Beachcroft Solicitors (representing Dorset Healthcare NHS Foundation Trust and University Hospitals Dorset) (3) REACH Drug and Alcohol Services

	(4) Walford Mill Medical Centre (5) Bristol Urological Institute (6) Alder Hey Children's Hospital (7) Advisory Council on the Misuse of Drugs 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	**Dated** 18th June 2026	**Signed**  **Brendan J Allen**