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FY1 1GB

Please quote our reference in your reply
Our ref: [redacted]
Your ref:
Date: 20th February 2015

URGENT - RESPONSE TO REGULATION 28 REPORT

By Post & By Email: coroners@blackpool.gov.uk

Dear Mr Wilson

MDU Member – [redacted]
Inquest touching on the death of Steven James Morris (Date of Death – 17th June 2013)
Regulation 28 Report request

I write following your letter dated 11th February 2015, the contents of which have been noted.

Thank you for confirming that [redacted] was not called to give evidence in the capacity of an Interested Person and accordingly, was not provided with notice of your intention to issue the Regulation 28 report.

I also note that you confirm that this matter was not a causative one, in that any concerns expressed in the Regulation 28 report did not cause or contribute to the death of Mr Morris. The position seems to be that the report was issued in an ancillary capacity.

Coroners are clearly given wide discretion as to whether or not in their judgement a Regulation 28 report ought to be made to prevent future deaths. The guidance to Coroners sets out that *"it is a pre-condition to making a report that "the coroner has considered all the documents, evidence and information and that in the opinion of the coroner is relevant to the investigation".* There is also a requirement that Coroners *"should be careful, particularly when reporting about something specific, to base their report on clear evidence at the inquest or on clear information during the investigation..."* It is unfortunate that these key points in the guidance appear not to have been followed in this case.

In the light of the supporting evidence that is being provided, it would appear entirely unreasonable and inappropriate for a Regulation 28 Report in the form and wording it appears to have been directed to [redacted]. If the relevant GP records had been requested and reviewed fully during the inquest process, it is respectfully submitted that the concerns expressed would have been allayed.

Notwithstanding the above, this response is being provided in the capacity of a formal response. It is emphasised that [redacted] is responding without having the benefit of reviewing the statements of any of the other witnesses who attended the first day of the inquest (23rd September 2014). [redacted] was unable to attend on that day and was therefore called to give evidence separately on 15th October 2014.

I adopt the wording as set out in section 5 of the Regulation 28 Report and provide [redacted] responses with supporting evidence.

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"I am concerned that medication was prescribed to a patient you knew had previously been referred to the local hospital Trust is respect of his mental health and the diagnosis that had been made."

The nature of the concern expressed in this point is unclear. Given the multi-disciplinary approach of medical care within the NHS, it is entirely conventional for GP to prescribe medication in line with recommendations from other medical practitioners from the Hospital Trust or from tertiary services.

"That you prescribed the medication on the basis of verbal information provided by the Patient rather than seeking some confirmation from those within the Hospital Trust with responsibility for the Patient's medical health care provision."

This is incorrect. It is clear from the GP records and [redacted] evidence that following his consultation, he telephoned [redacted] office and verified the position as to the recommendations made by the Community Nurse Practitioner. [redacted] however confirms that it is his standard practice to verify information from the patients as to medication changes and he did so in this case by telephoning [redacted] office. From an administration perspective, [redacted] will ensure that he in future requests that the Consultant Psychiatrist or Community Nurse Practitioner confirm any change of prescription in writing. Given that the patient was deemed to require that medication, it would have been inappropriate for [redacted] to have deferred issuing the prescription pending the receipt of written confirmation. If he had done so, this could well have formed adequate grounds for a complaint against [redacted] and could have broken down the doctor-patient relationship.

Within the GP records, there is a letter dated 17th June 2013 from the deceased's Psychiatrist, [redacted] (copy **enclosed**) which confirms that he was aware of the medication that the deceased was taking as at 4th June 2013, the date of their consultation. Under "Current medication", he lists *"Mirtazapine 45mg od"* and also *"Lithium 1200mg daily"*. He states in his letter *"I have not made any changes to his current medication as he tells me that he is happy with this although the treatment regime he is on isn't ideal for a diagnosis of Bipolar Disorder, i.e The anti-depressant. Ideally, I would like to see Steven for a longer appointment to be able to take detailed history...we will try to arrange that for the future."*

It is evident that a Consultant Psychiatrist had a consultation with the deceased some one month after [redacted] prescription and did not express sufficient concern to change the medication regime in place.

"That knowing the diagnosis, you prescribed medication you acknowledged was not the preferred medication for this Patient's condition and seemingly in the absence of discussion with those who had responsibility for the Patient's mental health care."

It would appear that when [redacted] gave evidence, he reiterated the comments of [redacted] in the letter dated 17th June 2013. Please refer to the points made above.

It is highly pertinent that the medical records reveal that the deceased was on a medication regime including Mirtazapine (45mg daily) together with Lithium (200mg – six times a day) from around May 2009 to December 2011 continuously without any reported issues and there are many items of correspondence from previous treating Psychiatrists setting out this regime during that period without any concerns being raised. (Extract of medical records **enclosed.**)

There is a relationship of trust and confidence between a doctor and patient and a doctor must take in good faith a history given by a patient, especially where there are no concerns about the reliability of the information given. Although [redacted] had no concerns of that nature about the deceased, in line with his standard practice, he did take the step of verifying the information given to him as has already been set out.

I would be grateful if you could proceed to serve this letter on the Chief Coroner in the capacity of [redacted] response to the Regulation 28 report dated 1st December 2014.

Yours sincerely

Fatema Begum
Solicitor

Enc.

1. *[redacted] statement to coroner dated 8th August 2013*
2. *[redacted]s letter dated 17th June 2013*
3. *Extracts of GP Records*