	Senior Coroner, London Inner South, UK **Re: Laurence Boyens, [redacted]** **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS** **THIS REPORT IS BEING SENT TO:** 1. [redacted] Head Healthcare, HMP Belmarsh, Western Way, London SE28 0EB 2. [redacted] Director of Fitness to Practice, General Midwifery Council (practice referrals) Standards and Guidance Department, 23 Portland Place, London W1B IP2 3. [redacted] Director of Fitness to Practice, Fitness to Practice Department, General Medical Council, Regent's Place, 350 Euston Road, London NW1 3JN
	CORONER I am Andrew Harris, senior coroner for the jurisdiction of London Inner South
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 November 2012, I opened an inquest into the death of Mr Laurence Boyens, who died on 15h November 2012. The inquest was concluded on 25th January 2015. It was recorded that the medical cause of death was: 1a Methadone, Tramadol and Diazepam intoxication In their narrative, the jury concluded that death was caused by: • The combination and interaction of prescribed drugs and • The failure to follow the *Clinical Management of Drug Dependence in Adult Prison Settings Guidelines 12.3 and 12.4,* specifically with acting on Laurence Boyens's lowering blood pressure. The jury further recorded: *There was neglect in providing basic medical care by way of the failure to suspend and withhold Methadone and Tramadol when [he} was exhibiting signs of toxicity on 13th November, which was a most significant contributing factor to his death*

4	**CIRCUMSTANCES OF THE DEATH** The jury also concluded, *inter alia*, that the following factors had contributed to death: • There was no continuity in monitoring of intoxication symptoms and review before the administration of medication to be able to assess changes • There was no documented guidance on respiratory assessment with regards to intoxication and • There was an inadequate 5 day review, leading to his transfer to House Block 4.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. **MATTERS OF CONCERN** are as follows. **1. There appeared to be a general misunderstanding how health care professionals should comply with** *DH Clinical Management of Drug Dependence in Adult Prison Settings Guidelines 12.3 and 12.4* b. **In particular this relates to the requirement to ensure that patients who are undergoing Methadone or Buprenorphine stabilization have not experienced a *lowering* of blood pressure or drowsiness before administration of the controlled drug.** • **Health care assistants routinely took the blood pressure before administration but did not inform the nurse of the reading and may not have had instruction when to report the reading** • **The evidence of six nurses and a health care assistant showed that previous blood pressure recordings were not sought or examined to determine if there had been a lowering of BP** • **The record of blood pressure was often written on paper and not usually entered in the medical records at the time and sometimes not at all** • **A health care assistant who did record a BP of 93/68 was asked by a nurse to repeat it and reported back to the medication hatch that it was still low. No apparent action was taken by nurses to suspend the medication or escalate the concern to a doctor on 11th.** • **One nurse, who did not see the BP of 93/58 recorded in the records and administered Methadone, did not know what he would do if he had discovered a previous higher BP.** • **One nurse was surprised that a BP of 105/60 having a reading of 128/68 and 93/68 the previous day and 121 /81 the day before that, should trigger withholding Methadone and escalating to the doctor.** • **The expert GP, who had been clinical director in the health care team provided to the prison, identified a sequence of seven BP recordings over 4 days, six of which (the second was considered rogue) should have triggered suspension of administration of drugs and escalation to the doctor, but in no case did this occur.** • **The head of health care at the time, who was an experienced nurse, did not accept that advice and asserted it would be impractical to implement it, as it would lead to significant delays.** • **In a local policy on Buprenorphine a threshold triggering suspension of drug and escalation was defined as 90/60 without reference to the trend. None was found in a section on Methadone and no definition of lowering of blood pressure or how to record it was found in any local policies.** • **No nurse saw the entry in the medical records by a doctor at 18.56 on 13th November which read: "** ***Unusually drowsy. Eyelids close when not engaged. communicative alert. no sadness or dsh. Plan stop Citalopram and monitor for signs of overdose.. may req further urine test before further Methadone testing...".*** • **At 17.57 on 13th, one hour from the doctor's assessment, when he must**

have been unusually drowsy, no nurse found him drowsy when he presented at the hatch for medication, and he was given Methadone and Tramadol.

- **On the morning of 14th he was given further Methadone and Tramadol, without measuring the blood pressure, or testing, as the previous day was last day of his Methadone titration regime and his 5 day review.**

2. Nurse [redacted]

Nurse [redacted] was called during the course of the inquest, and although given the opportunity, did not have legal representation in the proceedings.
The evidence from [redacted] himself that caused concern included:

- **A blood pressure of 93/58 was not a worry to be brought to the attention of a doctor.**
- **A blood pressure of 93/58 was not an indication to suspend Methadone and Tramadol administration in a drug titration regime, which he administered on 13th.**
- **It was outside his knowledge whether Methadone and Tramadol can cause low blood pressure.**
- **Despite a BP two hours earlier of 93/58 and of 112/58 on the 13th at the 5th day assessment, the nurse, finding dilated pupils and a report of mild symptoms at night suggestive of withdrawal, said the BP did not matter as he was feeling well and recommended an increase in Methadone.**
- **It was not recorded in the records, but it was reported that he was informed by a health care assistant that Mr Boyens was unusually drowsy on 13th, and that his cell mate thought so too. He was told of concerns that Mr Boyens was on the wrong medication and ensured that he saw a doctor, but did not pass these concerns to the doctor himself.**

The head of health care considered that his clinical practice raised concerns in relation to future risks to patients. He had failed RCGP Part I. He was currently on leave and she will be reviewing his performance.

3. Nurse [redacted] was called during the course of the inquest, and although given the opportunity, did not have legal representation in the proceedings.
The evidence from Nurse [redacted] herself that caused concern about risks to future patients included:

- **She did not record a BP at 18.35 on 10th, or at 09.25 on 11th, prior to administration of Methadone.**
- **She did not notice a BP of 93/68 recorded on "System One" at 15.27, before she administered Methadone at 17.50 on 11th.**
- **She expected the health care assistant to inform her of an abnormal blood pressure, but has not set any parameters, prior to Methadone**
- **She never looked at previous blood pressures prior to administering Methadone.**
- **She never makes respiratory rate recordings in monitoring patients on controlled drugs**
- **If she had seen the blood pressure of 134/113 that was recorded at 09.21 on 12th November, she would not do anything different.**
- **Given that her drug administration clinics were very busy (60 people per session), she was asked whether it would make any difference to what she did, if she saw half as many patients, but she said she would still not look at the blood pressures.**
- **Asked if she had changed her practice in any way since the incident, she said that she had not.**

The Head of Health Care reported that she had failed the RCGP course (part II) and that very clear performance issues were highlighted in the inquest. Asked why these concerns were not picked up in supervision, [redacted] said that a performance plan was not necessarily agreed, but the court has now given her enough support to address the issue. As the supervision process has not been able to resolve what appear to be serious performance issues over the last 2 years 4 months relating to both nurses, this report is brought to the attention of both HealthCare UK and the Nursing and Midwifery Council.

4. [redacted]

[redacted] was represented at the inquest and the following evidence gave rise to concerns:

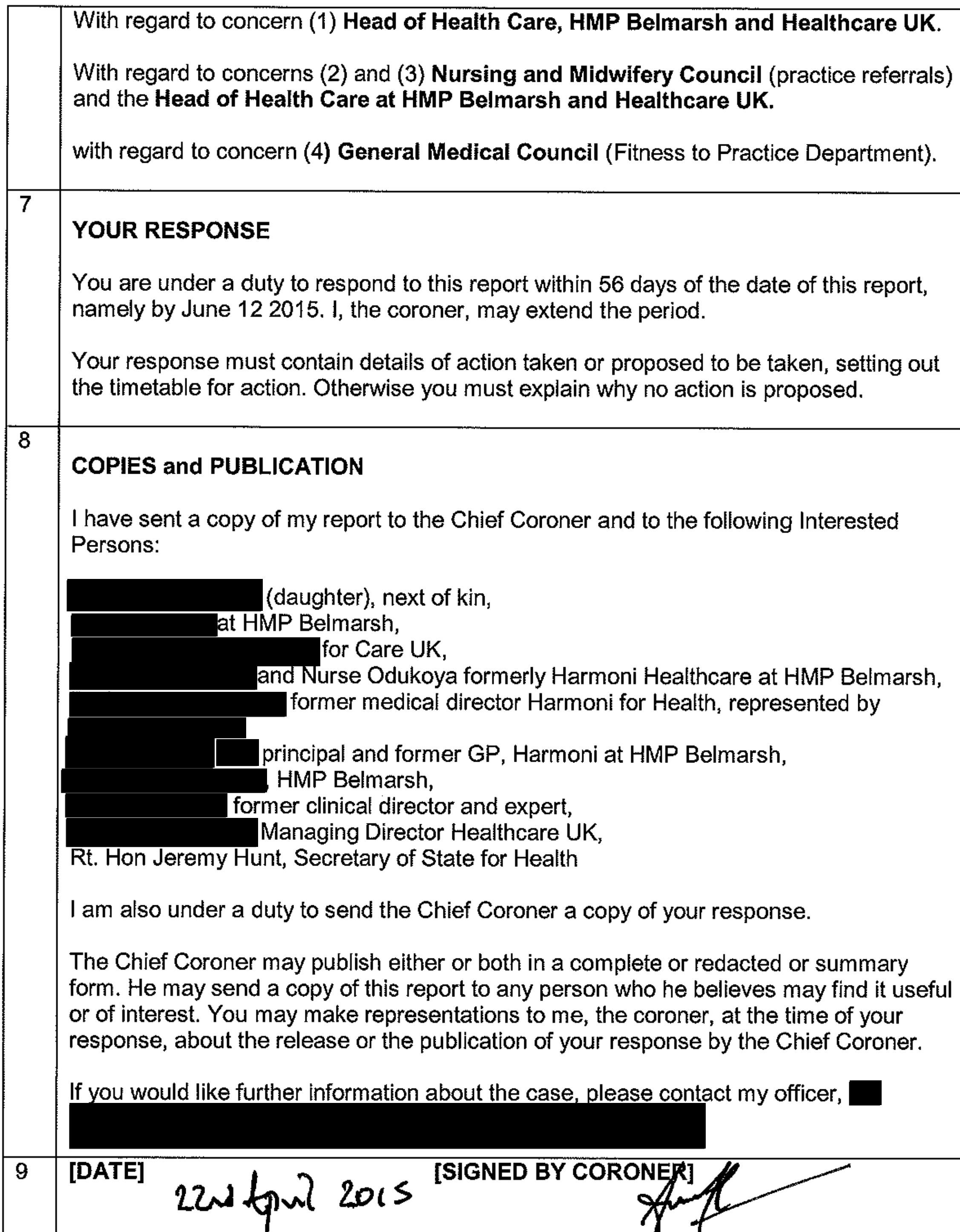
- **He prescribed Citalopram, Tramadol, Methadone, Diazepam and Sodium Valproate on 10th to a new patient without seeing him, although probably in possession of old medical records from previous stay in prison, but not those from his GP related to the period before detention in prison.**
- **When he saw the patient on 13th he failed to consider the interactions between Citalopram and Tramadol and between Citalopram and Methadone, both of which the prison expert [redacted] said were contraindicated, nor the summative effects of combining Methadone, Tramadol and Diazepam.**
- **He said that he was not aware whether withdrawal can cause low BP and thought the BP was measured to see if the patient was withdrawing.**
- **He said that he did not know whether he should stop Methadone if the BP was low.**
- **Mr Boyens was seen by the doctor on 13th, the day after another witness found him drowsy with "pinned eyes" and a few hours before another witness found him unsteady and drowsy. He made no record of the state of the pupils, but did record him as unusually drowsy.**
- **At that examination, according to his 2013 statement he considered the patient was drowsy due to lack of sleep; in a 2015 statement he considered use of illicit drugs and was aware of the possibility of Methadone toxicity. But he failed to stop these drugs from continuing to be administered.**
- **At this assessment on 13th he recorded an intention to stop the Citalopram on the request of the patient, but did not take the simple steps to cancel the prescription on the computerised record and if he told a nurse about this instruction it was not recalled or noted by them, and continued to be administered.**
- **He gave evidence that he would not administer Naloxone to a patient unless the patient was blue and unconscious and known to have taken opiates and did not know any disadvantages of doing so. [redacted] gave evidence that this was not correct and that Naloxone properly administered had the potential to save lives.**

The court was informed that [redacted] had received a warning from the GMC. From this it appears that the last two pieces of evidence above were not known to the GMC. It further was noted that the GP no longer works in prison health care but as a full time GP principal, with continued prescribing responsibility for those with drug problems in a polyclinic. This report is brought to the attention of the GMC so that it can determine whether the further evidence raises concerns about the safety of current patients of the doctor, which require action.

6

ACTION SHOULD BE TAKEN

The following organizations are asked to consider the concerns arising from this case and whether any action is needed to reduce the risk of other deaths.



	With regard to concern (1) **Head of Health Care, HMP Belmarsh and Healthcare UK.** With regard to concerns (2) and (3) **Nursing and Midwifery Council** (practice referrals) and the **Head of Health Care at HMP Belmarsh and Healthcare UK.** with regard to concern **(4) General Medical Council** (Fitness to Practice Department).
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by June 12 2015. 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: (daughter), next of kin, at HMP Belmarsh, for Care UK, and Nurse Odukoya formerly Harmoni Healthcare at HMP Belmarsh, former medical director Harmoni for Health, represented by principal and former GP, Harmoni at HMP Belmarsh, HMP Belmarsh, former clinical director and expert, Managing Director Healthcare UK, Rt. Hon Jeremy Hunt, Secretary of State for Health 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. If you would like further information about the case, please contact my officer,
9	**[DATE]** 22nd April 2015 **[SIGNED BY CORONER]**