REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Chief Executive, Wandsworth Consortium Drug and Alcohol Services, St John's Therapy Centre, 162, St John's Hill, Battersea, London. SW11 1SW
1	**CORONER** I am Dr Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West London
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 9th January 2018, evidence was heard touching the death of **Ms Angela Caroline Byrne.** Ms Byrne had died at home on 29th July 2017. She was 54 years old at the time of her death. The findings of the court were as follows: **Medical Cause of Death** 1 (a) Methadone toxicity II Hepatitic Cirrhosis **How, when and where the deceased came by her death:** Angie had a long history of relapsing and remitting drug misuse. On 29/07/2017 she took an accidental overdose of prescribed and illicit drugs which led to and caused her death. **Conclusion of the Coroner as to the death** Misadventure

4	**CIRCUMSTANCES OF THE DEATH** Ms Byrne had a very long history of drug dependence and drug misuse for which she was under the care of Wandsworth Consortium Drug and Alcohol Services. Her engagement in support services was erratic. She was on a long list of prescribed medication, namely pregabalin, metformin, mirtazapine and zopiclone and had recently been started on methadone, despite a history of impulsive binge drug taking. This was potentially more dangerous for her in overdose that the buprenorphine that she had been previously prescribed. She would intermittently also take drugs that she obtained illicitly for example benzodiazepines. She was at risk of sudden death due to respiratory depression from a combination of methadone, benzodiazepines and pregabalin. On 14th July 2017 she had been admitted to hospital unconscious after bingeing on prescribed and illicit drugs and discharged on the methadone which ultimately caused her death. The evidence was that W-CDAS who knew her better would not have prescribed this, but rather left her on drugs less risky in overdose, namely buprenorphine. It would appear that they were not consulted and this was exacerbated by two separate systems of clinical notes for in-patients and community patients. W-CDAS suggested that she switch back to buprenorphine rather than methadone to try and mitigate that risk but she declined. She denied any current suicidal intent. On the last day of her life she appeared in normal mood and had plans to go out her partner that evening on his return from home. Sadly he returned home to find her deceased and she was recognised at life extinct at 00:15 hours on the 29th July 2017. On Friday 28th July she had taken a supervised dose of methadone in the chemist and then brought home with her the doses for Saturday and Sunday. It was found that she had taken some of this methadone on top of her daily prescription. Whilst she was under the care of W-CDAS there was evidence that there was only occasional urine drug screening. This should have occurred more often. There was also evidence taken that that she should have been under the core team to allow closer prescribing and dispensing supervision, that her suicidal ideation had not been documented and that there was no crisis plan in place. Whilst care in keeping with her risks and complexity may have prevented her death, it could not be said on the balance of probabilities that it would have done so. There was concern expressed in the evidence that the practitioners involved in her care were not always applying the training that they had received appropriately, for example not documenting her suicidal and self-harm risks, and not completing a crisis plan. The main problem was said to be the fact that she was not under the core team, but instead had care and prescribing shared with the GP.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. 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. – 1. The staff at W-CDAS are not applying the training that they receive in practice. 2. That as a result of this, vulnerable patients such as Ms Byrne do not have their risks appropriately assessed and planned for.

	3. That communications between the inpatient and community services need to be improved. 4. That consideration be given to one consistent set of clinical records for both in-patients and for use in the community. 5. That patients with complex needs such as Ms Byrne are treated by the core W-CDAS team rather that via shared care with the GP.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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. [redacted] 2. [redacted] 3. [redacted] Consultant Psychiatrist, St John's Therapy Centre, 162, St John's Hill, Battersea. SW11 1SW. 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	**13th February 2018**  **Dr Fiona J Wilcox** **HM Senior Coroner** **Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED**