REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1. [redacted] Practice Manager, The Dower House Surgery, 27 Pyle Street, Newport, Isle of Wight, PO30 1JW.** **2. [redacted] Executive Director of Quality and Nursing, Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups, c/o CommCen Building, Fort Southwick, James Callaghan Drive, Fareham PO17 6AR**
1	**CORONER** I am Caroline Sarah Sumeray, Senior Coroner for the Coroner Area of the Isle of Wight.
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 1st March 2018 I commenced an investigation into the death of Nathan John COOKE, aged 36. The investigation concluded at the end of the inquest on 15th April 2019. The conclusion of the inquest was "Drug Related". The medical cause of death was found to be: 1a Cardio-Respiratory Failure 1b Severe Central Nervous System Depression 1c Methadone and Clomipramine Overdose II
4	**CIRCUMSTANCES OF THE DEATH** 1) Nathan John COOKE was born on 4th January 1982. At the time of his death he was 36 years old and was unemployed. 2) Nathan John COOKE was found dead by his mother at 16.30 hours at his home address of [redacted], Isle of Wight. He had last been seen by his mother when she had left the address that morning, but he was asleep at that point.

3) Mr COOKE had been prescribed a number of medications for his mental health and previous drug addiction issues, which included Methadone (an opioid drug which can be used for pain relief in some circumstances but is more commonly used as replacement therapy for heroin addiction or withdrawal) and Clomipramine (a tricyclic antidepressant drug where adverse reactions to excessive doses may cause cardiac arrhythmias, convulsions and central nervous system depression.)

4) Good practice dictates that when a patient is being prescribed Clomipramine, they should be monitored by ECG heart trace for the abnormal heart rhythm known as "QTc prolongation" which is a risk factor in sudden cardiac death.

5) Mr COOKE had been monitored in October 2017 and was found to have an abnormal reading with a QTc prolongation at 488 which could have been caused by the Methadone and Clomipromine. The guidance says that where there is a QTc of greater than 440, but less than 500, consideration should be given to reducing the dose of the medication or switching to a drug of lower effect, and repeating the ECG.

6) Mr COOKE and his mother were notified of this ECG concern, in particular the increased risk of potential heart arrhythmia and death.

7) Mr COOKE supplemented his prescription medication with illicit medication which had not been prescribed to him.

8) Mr COOKE was offered a number of appointments to attend for a further ECG – but he failed to attend them or declined to have the screen done when he attended for appointments. Efforts were made to reduce the dosage of the medication which he was being prescribed, with variable results.

9) It was acknowledged by the Drugs Worker who attended Court that it was important to convey to Mr COOKE (and other patients) that they absolutely needed to have a further ECG scan and review the results for patient safety. Whilst it was possible to decline to provide any further prescriptions to the patient to compel them to attend the surgery in order to obtain a prescription, this could be dangerous as it might precipitate them stopping their medication suddenly.

10) Whilst it is not believed that Mr COOKE suffered a fatal cardiac arrhythmia as a result of taking these medications, this was a risk factor which was not adequately addressed in his clinical management.

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. It was agreed that a more appropriate way to manage and control this situation whereby a patient is prescribed medication which could be dangerous to their welfare without regular monitoring would be for the primary care practice to write to the patient, inviting them to attend for a review, and informing them that if they failed to attend the review by a specified date, their medication would be reduced and eventually stopped. The incentive and responsibility to comply with clinicians is thereby passed to the patient.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 5th June 2019. 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: [redacted] and the Isle of Wight NHS Trust. 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	 **H.M. Senior Coroner – Isle of Wight** **17th April 2019**