REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Mr [redacted] Chief Executive Public Health England Wellington House 133-155 Waterloo road London SE1 8UG Mr [redacted] Chief Executive General Pharmaceutical Council 25 Canada Square Canary Wharf London E14 5LQ Head Pharmacist Haverhill Pharmacy Camps Road Haverhill Suffolk CB9 8HF
1	**CORONER** I am Nigel Parsley, Senior Coroner, for the coroner area of Suffolk.
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 24th April 2020 I commenced an investigation into the death of **Matthew Colin FITTEN** The investigation concluded at the end of the inquest on 20th November 2020. The conclusion of the inquest was that the death was the result of a- Drug related death The medical cause of death was confirmed as: **1a Methadone toxicity**
4	**CIRCUMSTANCES OF THE DEATH** Matthew Fitten was found deceased on the 17th April 2020 at his home address of [redacted], Haverhill in Suffolk. Matthew was found when a family member visited his home on the 17th April.

	Matthew was known to have drug dependency issues and had been receiving support from Turning Point the Suffolk Recovery Network. Matthew was last seen by his family on the 15th April 2020 and he appeared fit, well and in good spirits. Toxicology analysis identified a toxic quantity of a medication called Methadone in Matthew's blood at the time of Matthews death. Matthew received his Methadone prescription from Turning Point and prior to the Covid19 pandemic lockdown was prescribed this drug three times per week in daily dosage bottles. Due to CoVID19 restrictions Matthew's prescription was changed to once every 14 days. This meant Matthew had a much larger quantity of Methadone than he would normally have. The Methadone Matthew was given by his pharmacy was also not in daily doses as prescribed. Despite the risk mitigation put in place by Turning Point, Matthew's access to increased quantities of Methadone directly contributed to his death. Although the level of methadone in Matthew system was found to be much higher than the usual toxic level, there is no evidence to suggest that Matthew intended to take his own life.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you; the **MATTERS OF CONCERN** as follows. – **During the evidence it was heard that at the start of the Covid19 pandemic PHE guidance was issued to Turning Point (the Suffolk Recovery Network) that individuals on opiate replacement treatment (Methadone) should be moved off short term (daily or tri-weekly) prescription collections to longer term ones.** **In Matthew's case his collection was changed from 3 times per week to fortnightly.** **The doctor who made the changes to the prescription stipulated that Matthew's dose must be in single daily dosage bottles. Matthew had a secure store in his home and was used to taking his Methadone from single daily dosage bottles.** **In addition the Turning Point doctor had sent a letter to all of the pharmacy's that supplied opiate replacement therapies to his patients, explaining that only daily usage bottles should be prescribed.** **On the 15th April 2020 Matthew collected his 14-day methadone supply from the Haverhill Pharmacy in Haverhill, Suffolk** **Evidence produced by Matthews father during the inquest itself, clearly showed that Matthew had been issued three bottles of Methadone to cover the 14-day**

	period. These bottles contained 100ml, 156ml and 500ml of Methadone respectively. **In addition, because Matthew's prescription had been for single dose bottles a separate 'measuring jug' had not been prescribed by the Turning Point doctor.** **Matthew's prescribed dose of Methadone was 54ml daily. As such, when Matthew was given the 100ml, 156ml and 500ml Methadone bottles on the 15th April 2020, he was not given anything to accurately measure his daily dose from them.** **It is therefore probable, that due to a lack of a measuring jug, Matthew guessed his first dose from the larger Methadone bottles with tragic consequences.** **Had Matthew been given daily dose bottles of Methadone as prescribed, or a measuring jug and instructions on how to use it had been provided, on a balance of probability basis his death would not have occurred.**
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 1st February 2021 I, the Senior Coroner, may extend the period if I consider it reasonable to do so. 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, Matthew's Family. I am 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**7th December 2019** **Nigel Parsley**