REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: [redacted] **Chief Executive** **NHS England** **PO Cox 16738** **Redditch** **B97 9PT** **(1)**
1	**CORONER** I am **PENELOPE SCHOFIELD**, senior coroner, for the coroner area of **WEST SUSSEX**
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 INQU EST** On 24th September 2019 I commenced an investigation into the death of Parys Alan George Lapper which concluded at the end of a 5-day inquest on 14th January 2021. At the end of the Inquest I concluded "Parys was a young man with complex mental health issues. From a young age he had started to develop an excessive use of illicit substances and prescribed medications. He had been under the Child and Adolescent Mental Health Services and transitioned to the Adult Mental Health Services. Shortly before his death he had been discharged from the Adult Assessment and Treatment service as he had failed to engage with them. At the time of his death he was under the care of a private psychiatrist but there was no active treatment or provision in place to address his misuse of prescribed medication or illicit substances." Following the Inquest, I indicated that I was minded to make a Regulation 28 report but would like to hear submissions from the Interested Persons. Submissions have since been received from the family and those representing your Trust. I have fully considered these submissions prior to preparing this report and I apologise for the delay in finalising this Regulation 28 report.

4	**CIRCUMSTANCES OF THE DEATH**

	Mr Lapper was 19 years old at the time of his death. He had previously been under the Child and Adolescent Mental Health Services and had had an inpatient admission when he was 17 years old. He later went on and transitioned to the Adult Mental Health Services and was supported by the Leaving Care Service and the Community Mental Health Team. Mr Lapper had a diagnosis of Attention Deficit Disorder, Post Traumatic Stress Disorder, Poly substance Abuse and Emotional Dysregulation. In the lead up to his death Mr Lapper was able to obtain medication from several providers namely the Community Mental Health team, his GP, the local A&E hospital, and a Private Psychiatrist. Providers did not carry out any checks to look out for other possible providers (and indeed as there is no central record it appears that there is no mechanism in place to do this) before issuing a new prescription. This meant that the NHS did not know what a Private provider has prescribed and vice versa. This enabled Mr Lapper to play the system and obtain duplicate prescriptions and misuse the prescription medication. Sadly, on 13th August 2020 Mr Lapper was found deceased in his room at the Wolsey Hotel. The Police attended and they were satisfied that there was no 3rd party involvement. Ambulance paramedics attended but were not able to revive him and he was declared deceased at 1125hrs. A post-mortem examination was carried out on 19th August and a COD was given 1a Respiratory depression 1b Opiate and benzodiazepine toxicity.
5	**CORONER'S CONCERNS** During 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. – Mr Lapper was a young man who was struggling with mental health issues. He had become dependent on prescribed medication. He had made concerted efforts to obtain prescribed medication, in the lead up to his death, from a number of sources. He was able to obtain medication from the local Community Mental Health Team, his GP and A&E at the local hospital whilst also obtaining prescriptions from a Private Psychiatrist. During the evidence heard at the Inquest it was clear that individuals can very easily manipulate the current prescription system. As there is no central record of what prescriptions have been issued it appears very easy for individuals to play the system and thereby obtain excess medication. This can lead to the risk of an individual abusing the medication that can bring about a fatal outcome. Whilst the GP was made aware of some of the prescriptions that had been issued there is no mechanism in place for any provider to check what the individual has already been prescribed with by other providers **before** the new prescription is issued. It appears that the NHS and private providers act in isolation.
	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe 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 July 2021. 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] **Sussex Partnership Foundation Trust** **Dr** [redacted] 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	**Date 10th May 2021**  **Penelope Schofield, Senior Coroner**