National Medical Director
NHS England & NHS Improvement and
Interim Chief Executive of NHS
Improvement
Skipton House
80 London Road
London
SE1 6LH

HM Assistant Coroner
Mr Nicholas Moss QC
Cambridgeshire and Peterborough
Lawrence Court
Princess Street
Huntingdon
PE29 3PA

8th September 2021

[redacted]

Dear Mr Moss,

Re: Regulation 28 Report to Prevent Future Deaths – Samantha Jane Gould, died 2 September 2018

Thank you for your Regulation 28 Report to Prevent Future Deaths (hereafter "report") dated 28 May 2021 concerning the death of Ms Samantha Gould on 2 September 2018. Firstly, I would like to express my deep condolences to Ms Gould's family. I am very sorry it has taken so long to respond and would be grateful if you would convey my apologies to Ms Gould's parents.

Your report concludes Ms Gould's death was a result of suicide by an overdose of prescribed medication with a wider narrative as follows:

"There was a systemic weakness and failing in the lack of a protocol for [Child and Adolescent Mental Health Service – CAMHS] and the GP service to communicate with local pharmacies concerning 16-18 year old patients with mental health conditions who were at risk of deliberate overdose. Sam was therefore able to pick up older prescriptions on 1 September 2018 without challenge. It was those medications … that were fatal in the combined amounts Sam ingested on the night of 1-2 September 2018."

Following the inquest you raised concerns in your report to NHS England and NHS Improvement (NHS E/I) regarding the following points:

Point 1: There did not appear to be any national guidance or standards that directed or encouraged appropriate sharing of risk information and care plans with the local pharmacy. As a result, the pharmacy was unsighted on the fact that the treating psychiatric team had a safety plan involving Sam's parents being responsible for handling and administering all medication. Had the pharmacy been aware of this plan, it is likely that they would either have refused to provide the medication with which Sam overdosed or, at least, contacted Sam's parents or General Practitioner.

Point 2: A local protocol has now been introduced whereby the Cambridgeshire and Peterborough Foundation Trust's Child and Adolescent Mental Health Service ensures that any pharmacy used regularly by their patients aged 16-17 are (where appropriate) advised of relevant care plans, as well as the responsible GP being so informed. This is now to be part of mandatory training for CAMHS prescribing staff and is to be discussed in the local Joint Prescribing Group to ensure better communication between the local NHS Trusts, G.P.s and local pharmacies. Accordingly, action has already been taken in the local area to prevent similar fatalities.

Point 3: I am concerned that there is a risk of future fatalities if action is not taken at a national level to ensure that pharmacies are appropriately involved in medication safety plans for mental health patients aged 16 – 17, given that such patients may otherwise be able to obtain prescribed medication with which to overdose.

I have set out in the annex some information that is relevant to this tragic incident and if used appropriately will help us ensure the risk of this tragic incident happening again is minimised. To assist in this I have asked Dr [redacted], Deputy Chief Pharmaceutical Officer, to establish a working group to build on the work of the Joint Prescribing Group you mention, with the aim of rolling it out, or an improved approach, across the country within the next 6 months, and then subsequently to ensure that facilities like the Summary Care Record and other digital means are used to their full benefit.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

[redacted]

Professor [redacted]
National Medical Director
NHS England and NHS Improvement and
Interim Chief Executive of NHS Improvement

Annex

The Summary Care Record (SCR) is available to all community pharmacists to view. The SCR provides detail about a patient's current medication and any recent changes made by General Practice. The pharmacist must seek consent of the patient before they can view it unless they believe there are overriding concerns and it is in patient's best interest that they see the record.

If the patient's GP thinks it is helpful that additional information should be available to other clinicians who have access to the SCR they can seek agreement with the patient that additional information is placed in the SCR for those clinicians to view.

Not every patient has a SCR and this record does not include any special notes made about the patient, but it does provide the opportunity with appropriate consent in place to provide additional information:

"*You can also choose to add 'additional information' to your Summary Care Record. This will include significant medical history and details about immunisations, your information and / or communication needs and your personal preferences. This will only happen if both you and your GP agree to do this – and you should discuss your wishes with your GP practice."*

NHSE/I has identified that it would be helpful to suggest to GPs that additional information could be added to the SCR to flag that a local prescription plan is agreed. HSE/I's is working with NHS Digital to see how this information can be added .

NHS England » Notes about the Standard and Summary Care Records

1. NICE Guideline NG5 (Medicines Optimisation: the safe and effective use of medicines to enable to best outcomes) outlines that "Relevant information about medicines should be shared with patients, and their family members or carers, where appropriate, and between health and social care practitioners when a person moves from one care setting to another, to support high-quality care." GMC Good guidance in prescribing and managing medicines and devices outlines that prescribers "must share all relevant information with colleagues involved in your patient's care within and outside the team."

This includes the sharing of relevant information with the patient's chosen community to ensure safe onward care for the patient and communication of key information in relation to prescribed medication. To facilitate secure communication between community pharmacies and health professionals, every community pharmacy in England is required to have a pharmacy premises specific nhs.net email address. In addition, the Electronic Prescription Service system has the facility for prescribers to add key messages for the community pharmacy to the electronic prescription. The prescriber is also able to annotate any handwritten prescription with key information related to the prescribed medication.

Ref: Nice: 1 Recommendations | Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes | Guidance | NICE

GMC: Deciding if it is safe to prescribe - GMC (gmc-uk.org)