REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] CEO, Essex Partnership University NHS Foundation Trust** **2. [redacted], Clinical Commissioning Group**
1	**CORONER** I am Sean Horstead, Area Coroner, for the coroner area of Essex
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 27th November 2020 an investigation commenced into the death of 54 year old Fiona May Humberstone. The investigation concluded at the end of the inquest on 22nd June 2021. The medical cause of death was *'drug overdose'* and I recorded the following Box 3 findings: *'On the 21st November 2020 Fiona May Humberstone was found deceased at her home address, [redacted] Balmoral Road, Brentwood, Essex. She had died from an inadvertent overdose of Oromorph, a prescribed morphine medication, taken by her in conjunction with therapeutic levels of other prescribed medication.'* The conclusion of the inquest was one of 'drug related death'
4	**CIRCUMSTANCES OF THE DEATH** Fiona Humberstone (FH) had been under the care of the Essex Partnership University NHS Foundation Trust (EPUT) for several years as both an in-patient and in the community with a long history of mental health issues including OCD, anxiety, depression and frequent 'binge-drinking' alcohol misuse. She also suffered from chronic levels of pain consequent upon long-standing back and knee conditions which impacted her mobility significantly. She had been under the care of a pain clinic consultant since 2019. FH had been treated by the same attentive GP for many years and had been regularly prescribed pain-relieving medication, alongside further medication relating to her mental health issues. Following an alcohol related fall down the stairs at her home in January 2020 FH sustained a severe compound fracture of the right tibia and was hospitalised for a period during which she was prescribed liquid Oromorph sulphate oral solution for pain management. The Oromorph prescription continued after she left hospital as it assisted with control of the chronic pain from which she continued to suffer. Following a further alcohol related fall in June 2020 she sustained a damaged wrist and fractured ribs. FH lived alone but was in regular contact with, and was supported by, her two adult children both before and during the COVID 19 pandemic. Evidence disclosed that prior to and following the national lockdown in March 2020 her contact with EPUT clinicians was very limited: she had no access to the internet and was not seen face to face. She was reviewed by her consultant psychiatrist in February 2019 and, over the telephone, in

	April 2020. Evidence indicated that Mrs Humberstone continued to drink alcohol, although at more restrained levels following the fall in June. In the period immediately preceding her death FH's children had been concerned that they could not reach her by telephone; they went to the house and FH was found deceased in her bedroom. Police attended and confirmed no third-party involvement or suspicious circumstances. Toxicological investigations confirmed 'fatal' levels of morphine in conjunction with low, therapeutic levels of other medications (which, in combination, would have enhanced the sedative and depressive effects of the fatal levels of morphine consumed). A negligible amount of (likely PM effect) ethanol was recorded. Having considered all of the available evidence (including police evidence and that of the next of kin) I concluded that there was an insufficient evidential basis to establish, on the balance of probabilities, FH's settled intention to end her life at the time that she consumed the prescription medication; I considered an inadvertent fatal overdose likely.
5	**<u>CORONER'S CONCERNS</u>** 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) In her statement provided for the purposes of the inquest, FH's consultant psychiatrist listed the medications prescribed to FH at the time of her death but made no reference to the Oromorph. During the course of her oral evidence she confirmed that, at the time of her last review of FH in April 2020, she was entirely unaware that she had been prescribed this powerful morphine-based pain killer for a number of months. She also confirmed that had she known of the prescription for that medication it would have affected her risk assessment, given LH's continuing misuse of alcohol. She told the court that it was (and remains) her usual practice to rely entirely on the information regarding medication (including dosage and frequency) provided by the patient, even in telephone only consultations. She stated that she would only rarely (and certainly not routinely) check the accuracy of the account provided by obtaining a list of medication from the GP or other clinical records. *Although not causative in respect of FH's death*, I am concerned that the practice of relying entirely on a patient's account of current medication, in circumstances where significant mental health issues are often involved (including where there is chronic substance and/or alcohol misuse) gives rise to a serious risk of future deaths. As was accepted by the witness, any risk assessments, care plan reviews or further prescribing of (or alteration to) a medication regimen may in such circumstances be predicated upon incomplete, inaccurate and potentially dangerously misleading information. In my view the risk of future deaths is clear. (2) Further, oral evidence from a senior EPUT witness confirmed that the Trust could not, as the electronic systems were presently configured, readily access information held by GP practices regarding individual patients (and vice versa). It appeared that this evidence was provided by way of an explanation as to why accurate and up to date medication/prescribing information was not routinely obtained by clinicians in advance of reviews of patients. Absent any other system for ensuring swift and accurate information transfer between primary and secondary care providers, then the continuation of a state of affairs where a consultant psychiatrist is undertaking a review of a mental health patient *but does not have access to a definitive record of the medication presently being taken by that patient (and/or their concordance with prescribed medication)* gives rise to a conspicuous risk of future deaths. The EPUT witness suggested

	that this was a matter for the Clinical Commissioning Group (CCG) to address. (3) Issues regarding the necessity for access to (and adequate time for the consideration of) medical records including prescriptions for and concordance with medication *in advance of mental health reviews undertaken by responsible clinicians* has been raised in relation to mental health related death in Essex previously. I am concerned that the evidence from FH's inquest indicates that such matters remain unresolved.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 Monday 28th August 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: (a) [redacted], the children of the deceased; (b) Dr [redacted], the deceased's GP and his legal representatives, [redacted] of the MDU and [redacted] of counsel; (c) Mr [redacted] and his legal representative, [redacted] of Capsticks Solicitors. I have also sent it to Dr [redacted], President of the Royal College of Psychiatrists, who may find it useful or of interest. 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	**28th June 2021** **HM Area Coroner for Essex Sean Horstead**