REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) Relevant Pharmaceutical Bodies:** **(a) The Royal Pharmaceutical Society;** **(b) The General Pharmaceutical Council;** **(c) The Company Chemists' Association.** **(2) NHS England.**
1	**CORONER** I am NICHOLAS MOSS QC, assistant coroner for the coroner area of CAMBRIDGESHIRE AND PETERBOROUGH.
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. https://www.legislation.gov.uk/ukpga/2009/25/schedule/5 https://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** An investigation commenced on 13 September 2018 into the death of **SAMANTHA JANE GOULD (Sam) aged 16**. The investigation concluded at the end of the inquest on **16 April 2021**. The conclusion of the inquest was: • Sam died by suicide by an overdose of prescribed medication. • The main cause of Sam's death was her borderline personality disorder, which treating clinicians assessed to be related to allegations of prolonged sexual abuse in her earlier childhood. The disorder caused a persistent but unpredictable and fluctuating risk of serious deliberate self-harm and suicide. • There was a wider narrative conclusion, the aspect most relevant to this report being that: *"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."*
4	**CIRCUMSTANCES OF THE DEATH** There was a safety plan agreed with Sam's consultant psychiatrist whereby, although Sam was over the age of 16, Sam's parents would be responsible for her medication. On 30 August 2018, Sam's treating psychiatrist in the community made a change to Sam's medication giving her a paper prescription. Sam expressed a preference to tell her mother about the change in medication (new prescription of Topiramate) directly and the psychiatrist had to make a judgement call whether or not to breach medical confidence and tell Sam's mother about this directly. On balance she chose not to. In the event, Sam did not tell her mother about the new prescription. Shortly before 1 pm on Saturday 1 September 2018, Sam instead went to her local pharmacy with the prescription for Topiramate and Lorazepam. She collected those medications as well as

	older prescriptions for other medications she would previously not have known were being held there. At her home on School Lane, Fulbourn at some time after 01.23 on the morning of 2 September 2018, Sam took a very large quantity of some of the prescribed medications. She went to bed, fell unconscious and died within at most a couple of hours. The local pharmacy (who do not have access to patients' records on SystmOne) had not been told about the safety plan. As Sam was 16 years old, she was assumed competent to take her own prescriptions and the pharmacists had no immediate reason not to provide them to Sam, being ignorant of the safety plan.
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** are as follows:- (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. (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. However, (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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 **23 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. **NOTE** – There are ongoing reporting restrictions that prevent the publication of details regarding the alleged abuser of Sam and Chris. You must not refer to that person's identity in any way in your response and you should contact the Coroner's Officer if you require further guidance in this regard.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: • [redacted] (Parents) • Bottisham Village College • The Village Pharmacy, Fulbourn • Cornford House Surgery and [redacted] • Cambridgeshire Police and to the LOCAL SAFEGUARDING BOARD. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**28 May 2021**