REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chair of the Advisory Council on the Misuse of Drugs** **2. [redacted], Minister of Justice**
1	**CORONER** I am Guy Davies, Her Majesty's Assistant Coroner for Cornwall & the Isles of Scilly.
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 8th February 2019 I commenced an investigation into the death of 43-year-old Helen Spicer. The investigation concluded at the end of the inquest on 16th April 2021. The conclusion of the inquest was as follows • **Drug Related Death** The four statutory questions – who, how, when and where were answered as follows • **Helen Louise SPICER died on 4 October 2018 at Royal Cornwall Hospital Truro from an unintentional overdose of prescription morphine against a background of opiate dependency following treatment of chronic pain due to fibromyalgia.** The medical cause of death was recorded as • **1a acute opioid toxicity with high tolerance** • **1b fibromyalgia with long term opioid requirement** • **II Poorly controlled type 2 diabetes with established end organ damage and fatty liver**

4	**CIRCUMSTANCES OF THE DEATH** Helen was admitted to Royal Cornwall Hospital Truro on 1st October 2018 with diarrhoea and vomiting. Helen's regular medications on admission included oral morphine on an as required basis. Helen was in pain throughout her admission and received morphine on a controlled and limited basis. The findings of fact included the following. • Sometime after her admission on 1st October 2018 Helen acquired [redacted] of oramorph, without the knowledge of the medical team that were treating Helen. • These [redacted] of oramorph were lawfully dispensed on 2nd October 2018 following the presentation of a prescription issued to Helen. • Helen consumed [redacted] during her admission prior to her death. • The toxicology revealed that Helen consumed a significant quantity of oramorph after midnight on 4th October 2021, sufficient to cause her death at 5am that same morning. • The investigation and inquest were unable to ascertain who collected that morphine from the chemist on 2nd October 2018. This is because there are no requirements in relation to the dispensing of liquid morphine as regards the need for the prescription to be signed for on collection. • Morphine is classed as a Schedule 2 controlled drug for almost all preparations (injections, capsules, tablets, suppositories, granules and concentrated oral solution), however the [redacted] morphine sulphate oral solution is classified as a schedule 5 controlled drug (BNF 78 page 465). Schedule 5 preparations are deemed as having negligible risk of abuse. There are no restrictions on the import, export, possession or administration of these preparations, and safe custody requirements do not apply to them (including the need for them to be signed for when collecting from a community pharmacy) (Pharmacy and Medicines Law pg.218). This is despite a [redacted] morphine sulphate oral solution (schedule 5) containing the same quantity of morphine [redacted] of morphine sulphate [redacted] (schedule 2). • There is a risk of abuse of oral morphine.
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. – The absence of restrictions on the import, export, possession or administration of oral morphine, and the fact that safe custody requirements do not apply to them,

	including the need for them to be signed for when collecting from a community pharmacy.
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. I would be pleased to hear from you in relation to these concerns.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 25 June 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], Helen's husband • [redacted], Helen's father and mother I have also sent it to who may find it useful or of interest. [redacted], Chief Pharmacist, Royal Cornwall Hospital. 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	**30 April 2021** **Guy Davies**