

19 October

Sent by email

Dear Deputy Binet

Inquest: David Keith Morgan - Report to prevent future deaths

1. I am writing to you in your capacity as Minister for Health and Social Services in respect of an inquest that I presided over from 5 October to 13 October 2026, in relation to the death of David Keith Morgan (**David**). David died in a fire at his home in St Helier. A detailed speaking note setting out my findings and addressing the contribution made to the cause of his death by his deteriorating mental health is provided together with this letter.
2. David's family have described him as usually a quiet and private man. David had a history of anxiety, depression and agoraphobia and this created lifelong challenges for him with maintaining his weight, remaining in work and sustaining his personal relationships. David was someone who was vulnerable, but well loved by his family and until the final six weeks before his death, he received consistent support from them and his mental health remained relatively stable on prescribed pregabalin, mirtazapine and buspirone
3. In brief, the inquest found that the medical cause of David's death on 4 August 2025 was acute carbon monoxide poisoning resulting from exposure to the fire, contributed to by starvation/stress-induced ketoacidosis. However, the inquest also found that David's consumption of prescribed cannabis was the predominant cause of a sudden, sustained and substantial deterioration in David's mental health during the final six weeks of his life that contributed to his death.
4. This deterioration in David's mental health was characterised by impulsivity, disinhibition, paranoia, psychotic symptoms, disorganisation and impaired judgement. Entirely out of character, David started behaving in an erratic and inappropriate way, including by being aggressive towards his neighbours and making threats to harm himself or kill close family members. David also began writing on his walls and cluttering his home with bedding, clothing and household items which he had removed from cupboards and left on the floor.

Morier House, Halkett Place, St Helier, Jersey, JE1 1DD
Telephone +44 (0) 1534 441400 Email viscount@courts.je
Websites courts.je / jerseylaw.je

A Department of the Jersey Court Service



Royal Court of Jersey
Deputy Viscount

5. David's behaviour prevented David's family and GP from supporting him effectively in the weeks before his death, removing important protective factors. These behaviours contributed to the circumstances in which the fire started in his home and hampered rescue efforts after it began. These symptoms may also have contributed to David's failure to escape from the fire, despite his having the opportunity to do so.
6. The evidence heard at the inquest demonstrated several systemic concerns relating to the prescribing and governance of cannabis-based products for medicinal use ("**CBPMs**") in Jersey. These concerns are most acute in relation to the prescribing of unlicensed CBPMs containing THC, which are often supplied in the form of dried cannabis flower or oils. As reflected in the evidence to the inquest, unlicensed CBPMs have not undergone rigorous tests for quality, safety and efficacy, which are required of licensed medications. There is little, if any, evidence of the efficacy of unlicensed CBPMs for the treatment of the conditions they are prescribed for. Unlike licensed medications, unlicensed CBPMs are prescribed without specific guidelines on the dosage that should be taken and the conditions they should be provided for.
7. The evidence heard at the inquest also demonstrated that there were deficiencies in the processes for the sharing of safeguarding information between agencies with respect to a vulnerable adult like David who manifests a sustained deterioration in his mental health. There were also inadequate pathways for information to be shared between agencies and private sector entities, such as GP surgeries and cannabis clinics. Tackling these concerns has the potential to prevent similar deaths occurring in future.

Coroner's legal powers and public interest

8. One of the ways in which an inquest can serve the public interest is by drawing attention to the existence of circumstances which, if left unremedied, might lead to further deaths. To that end, Rule 12 of the Inquests and Post-mortem Examinations (Jersey) Rules 1995, permits me to report matters to the relevant person or authority with a view to preventing the recurrence of fatalities like that in question at the inquest.
9. In accordance with Rule 12, at the conclusion of the inquest into David's death, I announced that I would be writing a report to prevent future deaths addressed to you



Royal Court of Jersey
Deputy Viscount

as I believe that you have the authority to address many of the concerns that were identified, though partnership working with the Police and other agencies might also be required.

10. The purpose of this report is not to attribute blame. It is to bring to your attention matters where action appears necessary to reduce the risk of future similar deaths.

Concerns in relation to the governance of prescribing of CBPMs

11. The inquest received a helpful, detailed Briefing Note from a group of senior clinicians working for Health and Care Jersey (**HCJ**) on the prescribing of CBPMs. I am grateful to HCJ for preparing that Briefing Note, which proposed a set of minimum standards for the safe and defensible prescribing of CBPMs drawing on a range of relevant UK Clinical Guidelines, including those prepared by the National Institute of Clinical Excellence (**NICE**), the General Medical Council (**GMC**), the Royal College of Psychiatrists (**RCP**) and the Medicinal Cannabis Clinicians Society (**MCCS**).

12. It is important to recognise that the NICE Guidelines provide no support for the prescribing of unlicensed CBPMs. The Guidelines provided by the GMC and MCCS emphasise the need for a cautious approach to the prescribing of unlicensed CBPMs generally and for particular care to be taken in relation to those containing THC where a patient has a history of psychiatric illness. The Position Statement of the Royal College of Psychiatrists, which specifically considers whether there is evidence to support the prescribing of CBPMs containing THC for mental health conditions says, among other things, that:

*The propsychotic and anxiogenic properties of THC mean that **CBMPs containing THC (other than as a very small proportion) are unlikely to be helpful for any psychiatric condition**. If such products are prescribed in other health settings, clinicians must be aware of potential psychiatric complications. [Emphasis added]*

13. The HCJ Briefing Note and evidence provided to the inquest by Mr Weir on behalf of HCJ reflected that work is already underway in Government to impose controls on the prescribing of unlicensed CBPMs.

14. The evidence provided to the inquest demonstrated that the prescribing practice in relation to unlicensed CBPMs in David's case fell materially below the minimum



Royal Court of Jersey
Deputy Viscount

standards proposed by HCJ. I will summarise the evidence I received on these points briefly below.

(a) Inadequate patient assessment

15. In David's case the initial assessment of whether to prescribe unlicensed CBPMs and the periodic reviews of the effect of that prescribing were conducted remotely, by telephone, limiting the ability to assess David's presentation, behaviour, cognition or mental state.
16. The prescribing decision was based primarily on David's self-report of his symptoms and the success of conventional treatments. There was insufficient evidence that the prescribers had properly considered David's medical records. For example, the prescribers did not identify that David was continuing to receive his prescribed pregabalin, mirtazapine and buspirone and they did not demonstrate that they had considered his history of alcohol dependency and his safeguarding vulnerabilities or poor nutrition. Crucially, the prescribers did not proactively seek relevant information that would have been available from David's GP or mental health services before prescribing.

(b) Failure properly to establish clinical need

17. The evidence before the inquest was that Unlicensed CBPMs should not be treated as first line medications, because of the risks presented and absence of safety checks. However, in David's case the prescribers did not demonstrate that they had considered whether licensed and evidence-based treatments had been exhausted, failed, or become unsuitable. In fact, David's anxiety and depression had remained relatively stable while receiving licenced medications prescribed by his GP.

(c) Inadequate specialist oversight

18. Although a Multi-Disciplinary Team (**MDT**) discussion occurred at treatment initiation, the discussion was only between two medical practitioners with a special interest in cannabis prescribing. There was no adequate contemporaneous record of the discussion and no meaningful evidence of challenge or scrutiny of the prescribing medical practitioner's assessment that David was a suitable candidate to be prescribed high-risk, unlicensed CBPMs containing THC. Indeed, such evidence as was provided to the inquest suggested that the medical practitioners who attended

the MDT were not familiar with the contents of relevant UK Guidelines when holding their discussion.

19. No input was sought at the MDT from David's GP or mental health services, and no further MDT review took place after the initial decision to prescribe, despite the prescribing medical practitioner's decision to increase first the potency and subsequently to double the quantity of cannabis prescribed on each prescription.

(d) Deficiencies in monitoring and review

20. The prescribing of unlicensed CBPMs continued based on the patient's self-reports of benefits at tri-monthly reviews of his treatment, conducted over the telephone between David and the prescribing medical practitioner. The strength and quantity of the cannabis flower prescribed was increased without any independent verification of the benefit to David and at the same time as his care was handed over to a pharmacist, reducing oversight of the prescribing.
21. Of grave concern, the prescribing clinic did not respond when David's GP wrote to them, informing the clinic of David's deteriorating mental health and erratic behaviour and the link to his cannabis intoxication. Despite David's GP expressing the view that continued cannabis prescribing was not in David's best interests, there was no evidence of an urgent reassessment or suspension of prescribing and the pharmacist continued to prescribe high-strength cannabis flower.
22. There was no robust mechanism for escalation when concerns were raised about cannabis prescribing by other professionals.

(f) Deficient communication arrangements

23. The prescribing clinic did not provide comprehensive information to the GP concerning the products prescribed, THC content, dosing and quantities supplied or of the monitoring arrangements that should be in place.

Other systemic concerns about CBPM prescribing

24. The evidence provided to the inquest suggested there were some further systemic governance deficiencies, which may also have influenced the prescribing practice in David's case.

25. The inquest heard evidence that in England, CBPMs may only lawfully be prescribed by a consultant level medical practitioner. However, Jersey law permits the prescribing of CBPMs by a broader range of practitioners, including GPs, pharmacists and other prescribers. This is a concern in relation to unlicensed CBPMs containing THC, which may be prescribed in strengths and quantities determined by the clinical judgement of the prescriber.
26. It was also identified that there is no single assurance mechanism overseeing prescribing activity and ensuring that there is adequate visibility and governance over prescribing. This increases the risk of patients obtaining multiple prescriptions, leading to the diversion of prescribed cannabis to other persons.
27. The evidence raised concerns that some cannabis clinics may create financial incentives for medical professionals to prescribe cannabis and continue repeat prescribing, even when that is not in a patient's best interests. In the absence of regulation and oversight, there are insufficient arrangements in place to protect against situations in which commercial interests could influence clinical decision-making. The risk created by such incentives is of particular concern when prescribing unlicensed psychoactive controlled drugs.

Information Sharing and Safeguarding Concerns

28. The inquest identified concerns regarding the flow of safeguarding information between agencies that arose in David's case. In particular:
- a. Adult Protection Notifications (**APNs**) were not shared with GPs where there had been three APNs submitted by the Police within thirty days. APNs were also not shared with the Fire and Rescue Service, even when they disclosed a particular fire related risk (in David's case the third APN reflected that he had threatened to set himself on fire).
 - b. The evidence reflected that the submission of three APNs within thirty days should have been a threshold at which further action was taken, however, no clear escalation process existed requiring multi-agency intervention.



Royal Court of Jersey
Deputy Viscount

- c. There were opportunities for coordinated intervention between the Police and Mental Health Services that were not taken.
- d. Opportunities for a face-to-face assessment of David by the Mental Health Crisis Team were missed, though steps have been taken since to introduce a triage tool to support the approach to assessments.
- e. The evidence identified an issue in relation to collaboration between the Mental Health Crisis Team and the Drug and Alcohol Service. Evidence suggested that there was uncertainty about which service retained responsibility for David's care after concerns emerged regarding cannabis intoxication. In David's circumstances, where concerns related to his use of prescribed cannabis, neither his GP nor the Crisis Team appeared to be aware that the Drug and Alcohol Service would not accept the referral despite escalating concerns.

Observations about reform proposals

29. It is a matter for you to determine how best to address the concerns I have identified, but I would just make some brief observations about the work that is already planned in this area.
30. The inquest was informed that you are already developing legislative reforms to introduce stricter controls and new governance arrangements in relation to the prescribing of CBPMs in Jersey. I understand that these would include the introduction, as part of a first phase of this work, of mandatory minimum prescribing standards, including requirements for:
- a. face-to-face assessment before prescribing;
 - b. mandatory review of relevant medical records;
 - c. a requirement for cannabis clinics to have a Jersey based responsible officer;
 - d. objective outcome monitoring and multi-disciplinary team reviews in the context of increases in the strength or quantity of cannabis prescribed;
 - e. mandatory consideration of psychiatric and safeguarding risks;
 - f. enhanced arrangements for high-risk prescribing; and



Royal Court of Jersey
Deputy Viscount

- g. restricting initiation of CBPM prescribing to appropriately qualified medical practitioners with relevant expertise.

31. I understand that a second phase of work may then include the introduction of a comprehensive licencing and regulatory regime for cannabis clinics operating in Jersey.

32. These measures, which are required urgently to reduce the risk of harm to vulnerable patients like David, would address several of the concerns that were identified at the inquest. However, I would just highlight that the evidence at David's inquest suggested that MDT reviews did not include input from those with a fuller knowledge of David's medical history, including his GP and mental health services. Input from those sources would have been relevant to prescribing decisions that were made. You may wish to consider whether there should be an obligation on cannabis prescribers to obtain a patient's GP's input before prescribing commences.

33. Further, I appreciate that it may take time to develop and consult on the reforms proposed. In the meantime, it is relevant to note the Royal College of Psychiatrists Position (as noted above), that unlicensed CBPMs containing THC are unlikely to be helpful for any psychiatric condition. The inquest heard evidence that suggested up to 50% of the prescriptions being issued for THC containing CBPMs are for psychiatric conditions like anxiety or depression. Depending on the speed with which additional governance requirements can be put in place, you may wish to consider whether a temporary moratorium would be appropriate in relation to the prescribing of unlicensed CBPMs containing THC for mental health conditions.

Conclusion

34. The death of David Keith Morgan exposed significant concerns regarding the governance of cannabis prescribing in Jersey and the effectiveness of information-sharing arrangements intended to protect vulnerable adults. The evidence demonstrated that the minimum standards for the safe and defensible prescribing of cannabis, as proposed by senior HCJ clinicians, were not in place in David's case. Those deficiencies contributed to a deterioration in his mental health which, on the balance of probabilities, contributed to his death.



Royal Court of Jersey
Deputy Viscount

35. Urgent action is required to address the concerns identified and mitigate the risk of future deaths occurring in similar circumstances.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Berry'.

Advocate Matt Berry

Deputy Viscount