REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mr Simon Stevens** **Chief Executive** **NHS England** **PO Box 16738** **Redditch** **B97 9PT**
1	**CORONER** I am JACQUELINE LAKE senior coroner, for the coroner area of NORFOLK
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 8th May 2012 I commenced an investigation into the death of Susan Edena Poore. The investigation concluded at the end of the inquest on 18th March 2014. The conclusion of the inquest was "Mrs Poore stepped in front of a train and suffered fatal injuries. At the time Mrs Poore was taking anti-depressant medication." The medical cause of death was "Multiple Trauma due to collision with a train".
4	**CIRCUMSTANCES OF THE DEATH** On 3 May 2012, Mrs Poore's family reported to local Police that she was missing. During that morning a train driver saw a person standing on the line near Thains Lane, East Runton. He reports that he sounded his horn but the person did not move. Despite applying his brakes the train did not stop quickly enough and struck the person causing fatal injuries. The person was later identified as Mrs Poore. Mrs Poore had recently been prescribed anti-depressant medication.
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 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) Shortly before her death, Mrs Poore had been prescribed anti-depressant medication (Mirtazapine 29.03.2012 changed to Fluoxetine 23.04.2012) (2) The evidence is that her depression deteriorated following her taking the anti-depressant medication and the mode of death was out of character for Mrs Poore (3) Although the medication did contain a message warning of the potential side-effect of worsening depression, this did not prevent Mrs Poore's death

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 May 2014, 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] I have also sent it to Doctors who may find it useful or of interest: [redacted] Sheringham Medical Practice The Health Centre Sheringham Norfolk NR26 8RT [redacted](Solicitor) MDU Services Ltd 230 Blackfriars Road London SE1 8PJ 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	**28 March 2014** Ubke.