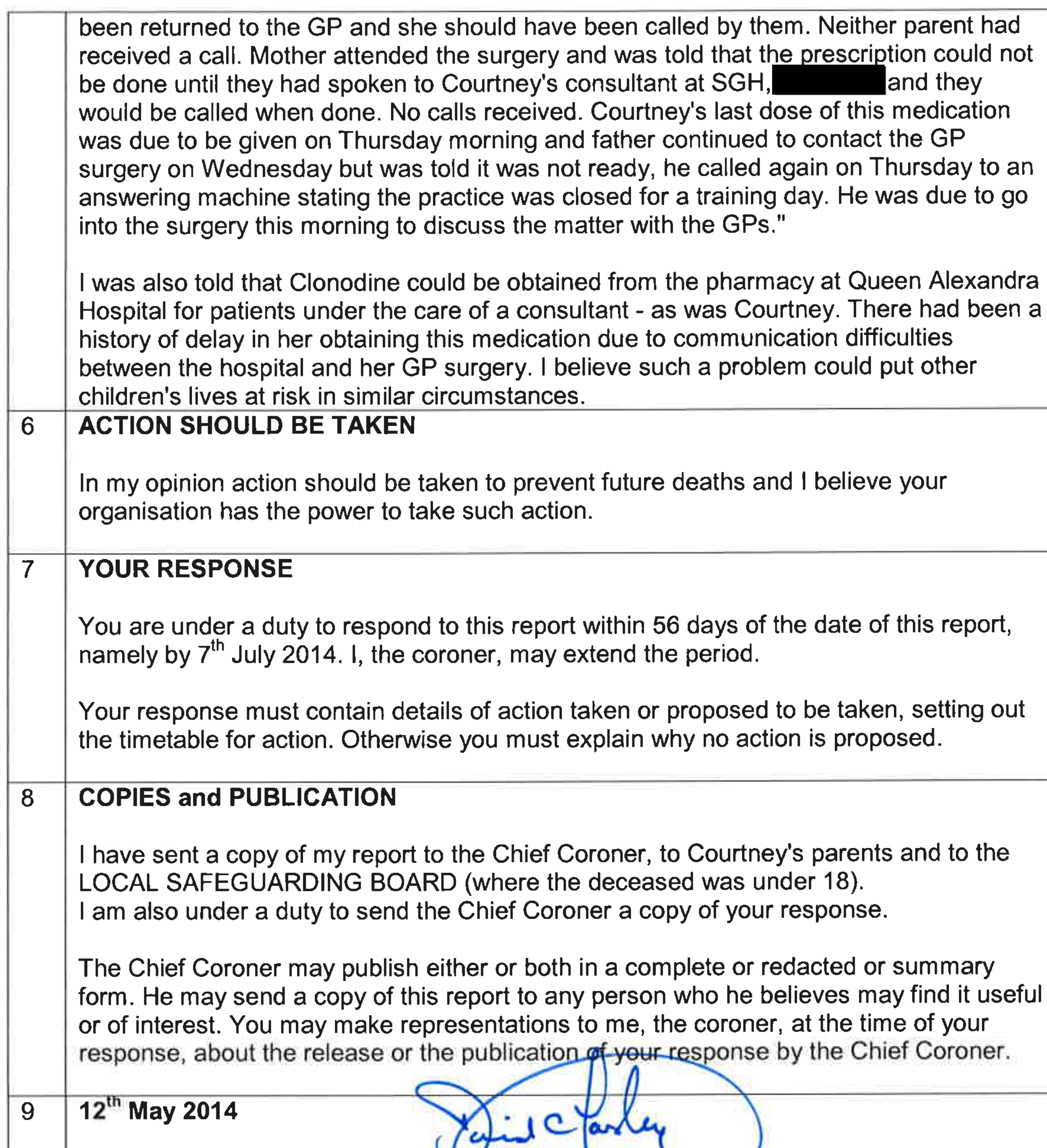
ANNEX A

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:** 1. **The Chief Executive, Portsmouth Hospitals NHS Trust** 2. **The Practice Manager, Waterside Medical Centre, Mumby Road, Gosport, PO12 1BA**
1	**CORONER** I am David Clark Horsley, senior coroner for the coroner area of Portsmouth and South East Hampshire.
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 2013 I commenced an investigation into the death of Courtney Jordan Mills, aged 11 years. The investigation concluded at the end of the inquest on 24th March 2014. The conclusion of the inquest was Medical Cause of Death: Acute Bronchopneumonia in a child with Sleep Apnoea and Cerebral Palsy. Coroner's Conclusion as to the death: Death due to Natural Causes.
4	**CIRCUMSTANCES OF THE DEATH** Courtney was found unresponsive in bed at her home on 19th April 2013. She was taken to Queen Alexandra Hospital, Portsmouth where she was pronounced deceased at 09.45 hours that day.
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. – I was told that (quote): "Courtney was on a quantity of different medication for her conditions one of which is "Clonodine". Her parents reported that they had been having problems getting the correct prescriptions for this from the GP surgery (written as tablets instead of solution, wrong dosage etc) and this caused problems. This drug cannot just be stopped as the patient suffers from withdrawal symptoms and has to be weaned off gradually. The drug was ordered in by the Pharmacist and could take 5 days to get in so the prescription was always requested in advance of when it was required. Courtney's supply was running low and a prescription was collected by mother and taken to the pharmacy. She returned a few days later she was told that the prescription had been written wrongly and had



	been returned to the GP and she should have been called by them. Neither parent had received a call. Mother attended the surgery and was told that the prescription could not be done until they had spoken to Courtney's consultant at SGH, ███████ and they would be called when done. No calls received. Courtney's last dose of this medication was due to be given on Thursday morning and father continued to contact the GP surgery on Wednesday but was told it was not ready, he called again on Thursday to an answering machine stating the practice was closed for a training day. He was due to go into the surgery this morning to discuss the matter with the GPs." I was also told that Clonodine could be obtained from the pharmacy at Queen Alexandra Hospital for patients under the care of a consultant - as was Courtney. There had been a history of delay in her obtaining this medication due to communication difficulties between the hospital and her GP surgery. I believe such a problem could put other children's lives at risk in similar circumstances.
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 7th July 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, to Courtney's parents and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18). 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	**12th May 2014**