REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Claire Murdoch, Chief Executive Central & North West London NHS Foundation Trust** **2. Cheri Jacob, Chief Executive NHS Hillingdon Clinical Commissioning Group**
1	**CORONER** I am Chinyere Inyama senior coroner for the coroner area of West London
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 15th March 2013 an investigation was commenced into the death of Tanya Rosemary Marion Oladejo then aged 36. The investigation concluded at the end of the inquest on 31st March 2014. The conclusion of the inquest was misadventure, the medical cause of death being amitriptyline intoxication.
4	**CIRCUMSTANCES OF THE DEATH** (1) Tanya was being seen as an outpatient by her responsible clinician and a clinical psychologist. (2) A friend, who hadn't heard from her for approximately one week, entered Tanya's property with her own key.. (3) Tanya was found collapsed and unresponsive face down on her bed. (4) Police confirmed there were no suspicious circumstances
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) The responsible clinician had made adjustments to the prescribed medication regime including allowing the GP to vary the amount of sertraline according to the patient's presentation. (2) The GP, in fact, also on occasion titrated the amount of amitriptyline prescribed according to the patient's presentation. (3) The responsible clinician was not made aware aware of the unilateral titration of amitriptyline so, accordingly, was unaware that a drug she had (in discussion with the patient) prescribed to be used as a sleeping draft was, in fact, being prescribed clearly labelled to be taken in the mornings. (4) In this case, there was a worrying lack of adequate communication between the GP practice and the responsible clinician about medication prescribed to assist

	in controlling Tanya's condition
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe each of you respectively have 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 17th June 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 Person: [redacted] (sister of the deceased) 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	**22nd April 2014** Chyana