ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted] **Axminster Medical Practice** **St Thomas Court** **Church Street** **Axminster** **Devon** **2.** **Ms M. Walker** **Chief Executive** **Devon Partnership NHS Trust** **Wonford House Hospital** **Dryden Road** **Exeter** **EX2 5AF**
1	**CORONER** I am Andrew Cox, an Assistant Coroner for the coroner area of Exeter and Greater Devon.
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 30 January 2014 I commenced an investigation into the death of Judith Anne SAVILLE, born on 18 September 1943. The investigation concluded at the end of the inquest on 18 December 2014. The conclusion of the inquest was that Mrs Saville had died from Zopiclone and Paracetamol overdose. I concluded that she had taken her own life.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Saville had a long history of agitated depression that had required multiple psychiatric admissions over many years and several courses of ECT treatment. Mrs Saville was discharged from the care of the Mental Health Team in October 2012 but re-presented to her GP, [redacted] at Axminster Medical Practice on 20 January 2014 with a deterioration in her condition. [redacted] agreed to make an urgent referral to the Mental Health Team but, having then been contacted by Mrs Saville's daughter, he was persuaded to expedite matters by contacting the Crisis Team.

	[redacted] increased an antidepressant Mrs Saville was already prescribed and also gave her 28 Zoplicone tablets. The Crisis Team contacted Mrs Saville by telephone that evening and then visited her the next day, Tuesday 21 January 2014. Mrs Saville was seen again on Thursday and Friday of that week before being discharged from the workload of the Crisis Team the following Monday. Mrs Saville was found deceased at her home address on Tuesday 28 January 2014.
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) For the attention of [redacted] In his evidence [redacted] told the Court that Mrs Saville's death had been reviewed at a significant events meeting in his practice. I was told that it was felt he had prescribed too much medication, particularly in a person who had a past medical history that included overdoses of prescribed medication. [redacted] said that there was now an increased awareness on the Practitioners not to prescribe so much medication in similar circumstances. He felt that a supply of no more than a week's worth of medication would be appropriate. [redacted] said that the system could be made more robust by introducing a warning on the firm's computer system. This would assist Practitioners by drawing to their attention a past medical history of overdose. It was felt that this may particularly be of benefit to locum doctors who would not necessarily have the same recall of a patient as a partner in the practice. (2) For the attention of Melanie Walker The Inquest heard evidence from [redacted] who had conducted a Root Cause Analysis into the circumstances of Mrs Saville's death. A copy of that Report is attached. [redacted] gave evidence that there were a number of lessons to be learned and that an action plan had been drafted. At Inquest I expressed my concern that the action plan was implemented and its effectiveness subsequently audited.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 12 March 2015. 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. 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, namely [redacted] 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	**Signed** ..... **Andrew Cox** **H.M. Assistant Coroner for the Exeter and Greater Devon area** **Dated** **15 January 2015**

Enc. Root Cause Analysis Report by [redacted] **Devon Partnership Trust**