REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Practice Manager, Lodge Road Surgery, Smethwick** **2. Black Country Partnership, NHS Foundation Trust**
1	**CORONER** I am Zafar Siddique, Senior Coroner, for the coroner area of the Black Country.
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 the 10 November 2017, I commenced an investigation into the death of Mrs Kaur. The investigation concluded at the end of the inquest on 15 January 2018. The conclusion of the inquest was a short narrative conclusion of suicide. The cause of death was: 1a Hanging
4	**CIRCUMSTANCES OF THE DEATH** i) Mrs Kaur had a medical history including Diabetes and also recurrent depressive disorder. She was also taking anti-depressant medication and zopiclone for insomnia. ii) She had increasingly become reliant upon zopiclone to help her cope with anxiety as well as insomnia and had been taking the medication for around 5 years. iii) She had a meeting with Speciality Doctor Psychiatrist on the 29 September 2017 and a recommendation was made to stop the zopiclone to avoid an accidental overdose. iv) However, after concerns raised by the family and further representations made to her GP, she did continue to receive zopiclone and this was tapered to reduce her levels over several weeks. v) On the 5 November 2017 she sadly took her own life by hanging at her home with a ligature around her neck

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. Evidence emerged during the inquest that Mrs Kaur had been a long term user of zopiclone and had effectively become addicted to this drug. 2. To prevent serious risk of self-harm a decision was taken to effectively stop the drug with immediate effect.
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. 1. There appears to have been little or inconsistent management of patients on long term zopiclone medication and lack of communication between the GP and secondary mental health services in managing medication. In light of this, you may wish to consider working in collaboration with the Black Country Partnership NHS Trust to review your systems and procedures in identifying long term users.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 21 March 2018. 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; Family. 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	**24 January 2017** **Mr Zafar Siddique** **Senior Coroner** **Black Country Area**