VERONICA HAMILTON-DEELEY DL, LL.B. Her Majesty's Senior Coroner for the City of Brighton & Hove

Assistant Coroners
CATHARINE PALMER LL.B (HONS)
KAREN HENDERSON, BSC,BM,MRCPI,FRC
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CORONERS SOCIETY OF ENGLAND AND WALES

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

| | THIS REPORT IS BEING SENT TO: 1. Brighton and Hove Clinical Commissioning Group 2. NHS England South (South East) 3. British Medical Association, Brighton and Hove |
|---|---|
| 1 | CORONER I am Veronica HAMILTON-DEELEY, Senior Coroner, for the City of Brighton and Hove |
| 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 Tenth November 2017 I commenced an investigation into the death of Ross REEVES. The investigation concluded at the end of the inquest on Twenty third March 2018. The conclusion of the inquest was Misadventure (Drug Related Death). |
| 4 | CIRCUMSTANCES OF THE DEATH See Record of Inquest |
| 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 transfer of this patient to his new GP was likely 'unsafe'. I am particularly concerned because in Brighton and Hove we have an |

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| | extremely high rate of drug related deaths. |
|---|---|
| | It seems to me that there were clues to this man's death and if there had been more information available to the new GP it is highly likely that they would have |
| · | taken different action with regard to him. In particular, they may well have prescribed his medications weekly rather than monthly. |
| | At the Inquest it was clear that only he had access to the medications that he |
| | collected on the 3 rd October, 2017 and that with regard to Gabapentin, Zomorph and Mirtazapine he took over one week's worth of each. This caused his |
| | sudden collapse, his state of profound stupor and his ultimate death due to a |
| | lobar pneumonia which developed during the time he was in such a state of profound respiratory depressions due to the drugs that he had been able to take. |
| | I would like it made clear that the Inquest is not a vehicle for apportioning blame however lessons must be learned and it was clear that better hand over of |
| | patients from one practice to another would provide a better chance for the |
| | manipulative patient who lies to his new GP to be picked up and dealt with adequately, hopefully preventing his death. |
| 6 | ACTION SHOULD BE TAKEN |
| | In my opinion action should be taken to prevent future deaths and I believe you AND your organisation 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 20 th June 2018, 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 |
| | 1. (Mother) |
| | St Peter's Surgery, Brighton Surrey and Sussex Local Medical Committee |
| | Secretary of State for Health, Department of Health Simon Stevens, Chief Executive, NHS England |
| | |

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| | 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. |
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| 9 | Date: 29 th March 2018 SIGNED BY: |
| | Volami tou Seeley |
| | Senior Coroner Brighton and Hove |
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