



H M Assistant Coroner for Gloucestershire
Ms Caroline Saunders

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>Gloucestershire Hospitals NHS Foundation Trust</p>
1	<p>CORONER</p> <p>I am Caroline Saunders, H M Assistant Coroner for Gloucestershire.</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On the 21/7/2017 I commenced an investigation into the death of Jonathan EARP.</p> <p>The investigation concluded at the end of the inquest on 25/4/18.</p> <p>The conclusion of the inquest was a Drug Related Death.</p> <p>The medical cause of death was determined to be:</p> <p>1a The combined toxic effects of Alcohol, Diazepam, Pregabalin, Fentanyl, cocaine, Zopiclone, Mirtazepine and Morphine</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Jonathan Earp died at 08:15 on 10/7/17 at Gloucester Royal Hospital from the effects of prescribed and non-prescribed drugs</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>I heard during the inquest that Mr Earp had been prescribed Fentanyl which was administered by way of transdermal patches. Mr Earp repeatedly requested additional patches however there was no evidence that all of the "unspent" patches had been returned to the nursing staff or appropriately discarded. The clinical staff believed that Mr Earp was accessing illicit drugs when he left the ward, however there was no evidence that staff considered that he may have been taking additional Fentanyl and illicit medication, and the effect this could have.</p> <p>I would ask that consideration is given to providing staff with guidance on how to manage the administration and provision of prescribed drugs when the patient is also accessing non-prescribed potentially illicit drugs</p>

6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 4pm on 10/7/18. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons</p> <ul style="list-style-type: none"> (1) Family [REDACTED] (mother and brother of the deceased) (2) (3) <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>Dated 8/5/18</p> <p>Signature <u>Caroline Saunders</u></p> <p>Caroline Saunders H M Assistant Coroner for Gloucestershire</p>