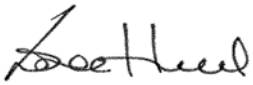
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Jockey Road Medical Centre**
1	**CORONER** I am Louise Hunt Senior Coroner for **Birmingham and Solihull**
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 21/10/2015 I commenced an investigation into the death of Edna May CLEATON DOB 30/08/1914, aged 101. The investigation concluded at the end of the inquest 16th December 2015. The conclusion of the inquest was that the deceased died from sepsis caused by sacral and leg pressure sores.
4	**CIRCUMSTANCES OF THE DEATH** The deceased died at her home address on 11/10/15. She had serious pressure sores which had become septic and caused her death. She had not been seen by a doctor for over 3 years despite being prescribed Citalopram for depression. The practice had been providing repeat prescriptions for this period.
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 evidence heard at the inquest was that patients on citalopram should be reviewed by a doctor every 3 – 6 months. This lady had not been reviewed for over 3 years. The practice need systems in place to ensure patients received appropriate medical reviews before repeat prescriptions are issued. Had regular reviews been undertaken it is possible that medical staff would have identified deterioration in the deceased and a care plan could have been instigated which may have avoided the pressure sores that developed.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Jockey Road Medical centre 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 12th February 2016. 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, Mr Cleaton and NHS England. 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	17/12/2015  Louise Hunt Senior Coroner **Birmingham and Solihull**