Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This from is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

Medicines and Healthcare Products Regulatory Agency
10 South Colonnade, Canary Wharf, London E14 4PU.

1 CORONER

I am Tom OSBORNE, Senior Coroner for the area of Milton Keynes

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 28/08/2019 I commenced an investigation into the death of Alana Molly CUTLAND aged 19. The investigation concluded at the end of the inquest on 30 April 2020. The conclusion of the inquest was:

I a Traumatic Injuries Following a Fall From A Plane

I b

I c

II

4 CIRCUMSTANCES OF THE DEATH

On the 25th of July 2019 the deceased open the door of a light aircraft that was flying from Anjajavay to Antananarivo in Madagascar and fell to her death. She was a student from Cambridge University carrying out research on the island. She had taken doxycycline as an antimalarial medication and it is believed that she suffered a psychotic/delirium event that led to her behaviour and death.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:
The deceased was prescribed doxycycline as an antimalarial medication for used whilst in Madagascar. It was quite apparent from the evidence that she had a psychotic reaction as a result of taking the drug and yet there is nothing on the drug information leaflet that either highlights or mentions this possibility. If she or her parents have been aware of this possible side-effect they may have been able to intervene earlier to avoid her death. In my view the information sent out with the drug should be reviewed.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 30 September 2020. 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;
The family of Miss Cutland.

I have also sent it to Professor [redacted] and Dr [redacted] who may find it useful or of interest.

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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Tom OSBORNE
Senior Coroner for
Milton Keynes
Dated: 05 August 2020