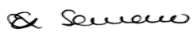
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Clinical Commissioning Groups ("CCG");** **2. NHS England;** **3. Primary Care Support England;** **4. Chief Coroner; and** **5. Family of the deceased.**
1	**CORONER** I am Emma Serrano, Assistant Coroner, for the coroner area of the Derby and Derbyshire.
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 10th February 2020, I commenced an investigation into the death of Mrs Christine Forbes. The investigation concluded at the end of the inquest on 22 September 2020. The conclusion of the inquest was a short form conclusion of suicide. The cause of death was: 1a Combined Oxycodone and Zolpidem Toxicity; and II Coronary Artery Atherosclerosis
4	**CIRCUMSTANCES OF THE DEATH** i) Mrs Forbes was a 72 year old woman who had a history of operation induced incontinence and pain management. She broke her leg in 2016 and this required treatment as well as pain management. She was prescribed oxycodone. In May 2017, having stockpiled her oxycodone, she took an international overdose. This was unsuccessful. ii) On the 29 September 2019 she again broke her leg. She was seen by a consultant at the Royal Derby Hospital. She was prescribed oxycodone. She was then prescribed oxycodone, by her usual GP surgery, the Bollington Practice, twice over the course of the following two months. iii) She registered with the Ashbourne Surgery in Derby on the 28 November 2019. This surgery had no information about Mrs Forbes. It is standard practice that, once a patient registers with a particular surgery, a request for their medical notes is made. This request is made to Primary Care Support England. It can take a significant amount of time for these to be sent. In

	relation to Mrs Forbes, her medical history and notes did not arrive with Ashbourne Surgery until shortly before Mrs Forbes passed away. iv) On the 11 December Mrs Forbes was prescribed oxycodone by Ashbourne Surgery's Pharmacist. This was done without the pharmacist having access to relevant information regarding Mrs Forbes, namely, her previous stockpiling and misuse of oxycodone and any previous episodes of self-harm or suicide. v) On the 2 February 2020 Mrs Forbes took oxycodone and zolpidem in quantities that caused her to pass away. She left a suicide note and her last will and testament for her husband to find. This was the same manner in which she had tried to take her own life in May 2017. vi) It was accepted, at inquest that the prescription of the oxycodone to Mrs Forbes was completed on the 11 December 2019, by Ashbourne Surgery's Pharmacist. This was done without the Pharmacist having access to the medical notes of Mrs Forbes. These would have contained her previous medical history and would have allowed for a more meaningful review before the decision to prescribe was made. vii) It was stated in evidence that it is usual for a new patient to register at a GP practice and, for the notes for that patient to follow a significant time after the registration.
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. That when patients register at GP surgeries (across England) they do so without their medical notes and history. This material can take a significant amount of time to be sent to a GP practice after a request is sent to Primary Care Support England. Doctors and other medical practitioners are therefore treating and prescribing in situations where a full medical history is not known.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 11 November 2020. 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. Clinical Commissioning Groups ("CCG"); 2. NHS England; 3. Primary Care Support England; and 4. Family of the deceased. 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	**23 September 2020**  **Miss Emma Serrano** **Assistant Coroner** **Derby and Derbyshire Coroners Area**