Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Alvaston Medical Centre**
1	**CORONER** I am Sabyta KAUSHAL, Assistant Coroner for the coroner area of 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 29 November 2018 I commenced an investigation into the death of Maria Susan MCGAURAN aged 48. The investigation concluded at the end of the inquest on 15 December 2021. The conclusion of the inquest was that: Maria Susan McGauran, date of birth 2nd January 1970, of [redacted] Derby, had on a long term basis been prescribed a combination of codeine and citalopram for her physical and psychological conditions respectively. Sadly before a pain management programme could be implemented, she died at her home address, due to the combined toxicity of those two medications on 28th November 2018.
4	**CIRCUMSTANCES OF THE DEATH**
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) Ms McGauran had over several years been known to take excessive amounts of her codeine prescription medication. She had a history of hoarding medication and taking her medication erratically. Her family raised concerns with the Surgery as to her reliance on several differing medications. They requested that a review of her medications be undertaken. No such review was undertaken. The Surgery could have considered alternative pain management aids at an earlier stage (such as the Fentanyl patches considered only 1 month before death i.e. in October 2018) so as to prevent the risks of overdose.
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 February 09, 2022. 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 [redacted] I have also sent it to [redacted] who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 20/12/2021**  **Sabyta KAUSHAL** **Assistant Coroner for** **Derby and Derbyshire**