REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Practice Manager, Swanage Medical Practice
1	**CORONER** I am Stephen John Nicholls, Assistant Coroner, for the Coroner Area of Dorset
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 13th August 2021, an investigation was commenced into the death of Mathew Christopher Moore, born on the 28th October 1961. The investigation concluded at the end of the Inquest on the 4th August 2022. The Medical Cause of Death was: 1a Hanging The conclusion of the Inquest recorded was Suicide.
4	**CIRCUMSTANCES OF THE DEATH** On the 7th August 2021 Mathew Christopher Moore died at [redacted], Bournemouth, Dorset having attached a rope as a ligature [redacted]
5	**<u>CORONER'S CONCERNS</u>** The **MATTERS OF CONCERN** are as follows: 1. During the inquest evidence was heard that: i. Mr Moore had a history of problems with alcohol. ii. A CT scan in January 2021 revealed a fatty liver.

iii. Mr Moore was admitted to hospital on the 2nd May 2021 complaining of abdominal pain and vomiting. When discharged from hospital on the 7th May 2021 it was noted that he had been consuming a bottle of whiskey per day. On the 19th May Mr Moore was prescribed [redacted] following a telephone conversation between a paramedic attending upon Mr Moore and a doctor at the surgery.

iv. On the 21st May Mr Moore's sister wrote to the surgery summarising her concerns for her brother and querying the medication that he had been prescribed. The surgery had no consent from Mr Moore to release any information to his sister. The We Are With You charity that offers free confidential advice to people with drug, alcohol or mental health issues were currently engaging with Mr Moore, they also raised concerns about the medication following a e-mail from Mr Moore's sister.

v. At a Significant Event meeting at the surgery when Mr Moore's case was discussed by doctors, it was agreed that the amount of [redacted] was potentially unsafe and a lesser amount should have been prescribed.

vi. The appears to be no documentation of Mr Moore being contacted and notified of these concerns.

vii. On the 27th May 2021 Mr Moore when was spoken to on the telephone by the surgery, there is no documentation that the concerns about [redacted] were discussed with him.

viii. On the 29th July 2021 Mr Moore when was seen by a doctor at the surgery, there is no documentation that the [redacted] concerns were discussed with him. Mr Moore told the doctor that he had no thoughts of suicide and was reducing his alcohol intake.

ix. Mr Moore continued to engage with We Are With You and had one to one sessions on the 27th July 2021 and the 3rd August 2021.

x. The use of [redacted] and excess alcohol together could cause death.

2. I have concerns with regard to the following:

i. There could be the death of a person in the future due to combined use of [redacted] and excess alcohol and I request that consideration is given to creating a policy at the surgery to cover patients who are prescribed [redacted], at the same time as consuming alcohol to excess.

ii. I would request consideration is given as to the advice to be given in the circumstances where a patient is not being seen face to face, but via another healthcare worker.

iii. Further, consideration should be given to the amount and dosage that should be prescribed in these circumstances and

	whether there should be a documented process to highlight any concerns about the use of [redacted] being brought to the patient's attention as soon as possible. iv. I would request consideration is given that within the policy there is provision for a follow up face to face meeting to review the medication. v. I would request consideration is given to the policy being available to all healthcare staff in the surgery.	
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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, by 4th October 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: (1) [redacted] (2) Care Commissioning Group 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	**Dated** **9th August 2022**	**Signed** S. J. Nicholls **Stephen J Nicholls**