Nhs rE

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: HEATHVIEW MEDICAL PRACTICE**
1	**CORONER** I am for **Stoke-on-Trent & North Staffordshire Coroner's Court**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 16/05/2022 I commenced an investigation into the death of Eirwen Rebecca Hollister, aged 38. The investigation concluded at the end of the inquest on the 5 October 2022. The conclusion of the inquest was misadventure. The medical cause of death was recorded as: 1a) [redacted] toxicity [redacted]
4	**CIRCUMSTANCES OF THE DEATH** Eirwen Rebecca Hollister had a past medical history of mental health issues. She was prescribed [redacted] by her GP, along with other medications to manage this. She had a history of taking overdoses of her prescription medications so, at the time of her death, she was on a weekly prescription of the medications. Eirwen Rebecca Hollister was registered at the Heathview Medical Practice in Tamworth. However, between the 21 September 2021 and the end of February 2022 she was also registered at the . During the time she was obtaining prescription medications from both practices at the same time. These were prescriptions of [redacted] NHS Registration Sutton Coldfield Group Practice has been contacted and can give no explanation as to how or why this has happened. On the 23 March 2022 she took an overdose, was taken to hospital and declined admission. ON the 22 April 2122 she took an overdose and was taken to the Good Hope Hospital and then discharged. Evidence was given at inquest to state that she her regular prescriptions should have been stopped until a full GP review had taken place. Reviews did not take place after either overdose and she was prescribed [redacted] on the 28 March 2022, the 1st, 4th 8th, 13th, 14th, 21st, 27th, and 29th April 2022 and the 3rd and 9 May 2021. She was found deceased at her home address on the 10 May 2022 and the cause of death found at inquest and after post mortem is: 1a) [redacted] toxicity together with [redacted]
5	**<u>CORONER'S CONCERNS</u>** 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) Evidence was given during the inquest that there was no process or procedure in place to ensure that when a patient, registered with the GP practice, took an overdose of prescribed medication, no prescriptions were issued before a full review by a GPO was undertaken. .

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you NHS Registrations and NHS England.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 29 November 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: (2) The family of Eirwen Rebecca Hollister; I am also under a duty to send the Chief Coroner a copy of your response and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other 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.
9	11/10/2022  Signature **South Staffordshire Coroner's Court**