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 [redacted] 2 3 **Chief Coroner - PFD Reports**
1	**CORONER** I am Robert SIMPSON, Assistant Coroner for the coroner area of Hampshire, Portsmouth and Southampton
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 11 January 2022 I commenced an investigation into the death of Tracy Marie BROWN aged 52. The investigation concluded at the end of the inquest on 06 December 2022. The conclusion of the inquest was that: On the 5th January 2022 Tracy Marie Brown died at her home address in Withington Close, Portsmouth after taking an excessive quantity of some of her prescribed medication. She had a history of psychosis and her mental health had deteriorated over the past month.
4	**CIRCUMSTANCES OF THE DEATH** Drug related
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) I heard evidence that medication for Ms Brown was required to be kept in a locked box due to a risk of her not taking the correct amount or taking too much medication. This was since Apex Care became involved in her care in March 2021. Despite this identified risk staff left regularly a nomad box containing a week's worth of medication unsecured in her kitchen cupboard. On the digital application used to inform carers of what medication to administer, which was used by the carers daily, there was no reference to keeping the medication in the secure box.
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 02, 2023. 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 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: 08/12/2022**  **Robert SIMPSON** **Assistant Coroner for** **Hampshire, Portsmouth and Southampton**