**ANNEX A**

**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

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

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. [redacted] Burton Croft Surgery, 1 Shire Oak Street, Headingley, Leeds LS6 2AF** |
| 1 | **CORONER**<br><br>I am Oliver Robert Longstaff, Area Coroner for the Coroner area of West Yorkshire (Eastern District) |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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. [HYPERLINKS] |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 13th September 2021 I commenced an investigation into the death of Aoife Rose McAdam, aged 19. The investigation concluded at the end of the Inquest on 24th March 2023. The conclusion of the Inquest was that Aoife's death was a misadventure. The medical cause of death was 1a) Cardiac Arrest; 1b) Intentional Propranolol Overdose; 2) Anxiety & Mood Disorder. The inquest found that the overdose had been taken as an impulsive act, in respect of which Aoife sought help, the provision of which was delayed. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Aoife died on 4th September 2021 in Leeds General Infirmary where she had been brought at 0823 hours having taken a significant overdose of propranolol at about 0430 hours. She rang the Crisis Team and NHS 111 within 30 minutes of taking the overdose. There were two opportunities missed to send her an ambulance sooner which would on the balance of probabilities have meant her reaching hospital at least two hours earlier than she eventually did. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) Aoife was prescribed propranolol by a locum GP at Burton Croft Surgery on 18th March to control the physical symptoms of anxiety by a locum GP at Burton Croft surgery. The prescription comprised 84 tablets (a maximum of three tablets to be taken daily as an as required medication). This was the only occasion on which she was prescribed propranolol.<br>(2) On the morning on 4th September 2021, when she took her overdose [redacted] |

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| | [redacted]<br>(3) On 12th August 2021, in a consultation with another GP at Burton Croft Surgery, Aoife reported that the Propranolol was not helping her and, following discussions and advice, she said she wished to switch to the antidepressant Sertraline, which was prescribed.<br>(4) In evidence, the GP present at that second consultation agreed that Aoife should have been advised safely to dispose of any propranolol tablets remaining from the earlier prescription by, for example, returning them to a pharmacist. Aoife was not so advised.<br>(5) Aoife, who by reason of her being prescribed an antidepressant was known to be in a potentially fragile mental state, was left in possession of a significant quantity of a medication known for its potential cardiotoxicity when taken in overdose and which she had stated she no longer wanted or needed.<br>(6) The primary cause of her death was an overdose of that potentially cardiotoxic medication, which she should not have had in her possession by 4th September 2021. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe Burton Croft Surgery ("your organisation" for the purposes of this report) has the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 24th May 2023. I, the Coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted] (Aoife's parents); Yorkshire Ambulance Service; NHS England; Leeds Teaching Hospitals NHS Trust; [redacted]<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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.<br><br>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 | 27th March 2023 |