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 Ashlea Medical Practice (Linden House)**
1	**CORONER** I am Krestina HAYES, HM Assistant Coroner for Surrey for the coroner area of Surrey
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 12 September 2023 I commenced an investigation into the death of Zarah RAVN aged 49. The investigation concluded at the end of the inquest on 20 February 2024. The conclusion of the inquest was that: Miss Zara Ravn, , aged 49 years old was found deceased on 3rd September 2023 from mixed drug toxicity at her home address in Leatherhead, where she had consumed a lethal dose of oramorph and oxycodone unprescribed and a prescribed drug of quetiapine leading to mixed drug toxicity.
4	**CIRCUMSTANCES OF THE DEATH** Miss Zara Ravn, , aged 49 years old was found deceased on 3rd September 2023 from mixed drug toxicity at her home address in Leatherhead, where she had consumed a lethal dose of oramorph and oxycodone unprescribed and a prescribed drug of quetiapine leading to mixed drug toxicity.
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) Miss Ravn was a female aged 49 years old when she was found deceased on 3rd September 2023. Ms Ravn was prescribed at the time of her death with fluoxetine (an anti-depressant) and also quetiapine (a medication for schizophrenia to help balance an individual's mood). On the evening of 2nd September 2023, Ms Ravn went to her bed. In the morning of 3rd September 2023, a family member found her deceased in her bed. Paramedics were called and attended and verified and declared that Ms Ravn passed away. A post-mortem examination was ordered and the cause of death at inquest was recorded as Mixed Drug Toxicity.

	The toxicological analysis showed multiple drugs including oramorph and oxycodone were unprescribed and she was also found to have taken a prescribed drug of quetiapaine. The large dose of morphine taken prior to death was sufficient to have caused acute fatal toxicity. The levels of quetiapine and oxycodone were also present in the blood at substantial levels which were sufficient to exacerbate the toxic effects of morphine. It was recognised that Ms Ravn was diagnosed with schizophrenia and depression for a number of years. Schizophrenia is considered as a Severe Mental illness and in accordance with National Guidelines the GP Practice are obliged to carry out Mental Health Reviews, Physical Reviews and also Medication Reviews annually. It was found in evidence that these had not been carried out for a number of years. There was found to be a lack of monitoring that these reviews had taken place and no standardised process for review. I was advised in evidence that the GP surgery had implemented a new system to identify all patients in need of reviews due to Severe Mental Illness in 2022, however, despite this, Ms Ravn had not had a review in 2022 or 2023. Furthermore, prior to the implementation of the new system in 2022, she had not had a mental health or medication review in 2021 or 2019. I was told at Court that this system of ensuring Severe Mental Illness reviews were now effective, however despite a request to provide supporting evidence of the effectiveness of the measures now in place the GP surgery have not provided such evidence. During the inquest, it was also identified that when Miss Ravn had reported a dip in her mental health in February 2022, no risk assessment was carried out at the time and her dip in mental illness was put down to her pre-menopausal symptoms which was affecting her schizophrenia. After she was prescribed HRT to treat the dip in her mental health, no follow up was carried out to check the effectiveness of the medication contrary to NICE guidelines on prescribing and management of the patient and medication. No clear evidence has been provided as to how the GP surgery intend to ensure that the review following initial prescription will take place. I consider that there is a risk of harm if mental health reviews, medication reviews and physical reviews are not undertaken at regular intervals, including a risk of death in cases, like Ms Ravn. There is a risk of harm of death if all pertinent matters are not considered during these reviews and loss of opportunities to take interventions when viewed necessary. Concerns: Lack of compliance with NICE guidelines in carrying out yearly medication reviews, mental health reviews and physical reviews leading to lack of opportunity to take necessary interventions including medication adjustments and provision of necessary support. Lack of compliance with HRT reviews following initial prescription in line with NICE guidelines.
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 July 01, 2024. 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. Family of Zara Ravn** I have also sent it to • **Care & Quality Commission** 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: 08/05/2024** **Krestina HAYES** **HM Assistant Coroner for Surrey for Surrey**