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 The Park Surgery (Heanor)**
1	**CORONER** I am Sarah HUNTBACH, Assistant Coroner for the coroner area of Derby and Derbyshire
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 22 June 2023 I commenced an investigation into the death of Debra BATES aged 55. The investigation concluded at the end of the inquest on 13 June 2024. The conclusion of the inquest was that: Debra Bates was found dead at home on 15 June 2023. Post mortem toxicology found prescribed medication at above therapeutic levels in her blood. On the evidence Debra has taken a mixture of prescribed medication in quantities that have had an enhanced sedative and respiratory depressant effect leading to her death. For many years Debra has suffered with her mental health and chronic pain. This was managed by the specialist healthcare teams and her GP. On 12 April 2023 following an admission to hospital following an overdose causing opiate toxicity it was recommended that the prescribing of her medication be changed to 4 day and 3 day prescriptions to minimise the risk of overdose. This did not happen. Debra continued to be prescribed her medication at 7 day intervals plus breakthrough pain medication as required. Debra had a chaotic approach to taking her medication. Whilst limiting the amount of medication prescribed to Debra at regular intervals would have reduced the amount she had access to at anyone time it cannot be established on the evidence that it would have prevented the overdose and her death.
4	**CIRCUMSTANCES OF THE DEATH** Debra Bates was found dead at home on 15 June 2023. Post mortem toxicology found prescribed medication at above therapeutic levels in her blood. On the evidence Debra has taken a mixture of prescribed medication in quantities that have had an enhanced sedative and respiratory depressant effect leading to her death. For many years Debra has suffered with her mental health and chronic pain. This was managed by the specialist healthcare teams and her GP. On 12 April 2023 following an admission to hospital following an overdose causing opiate toxicity it was recommended that the prescribing of her medication be changed to 4 day and 3 day prescriptions to minimise the risk of overdose. This did not happen. Debra continued to be prescribed her medication at 7 day intervals plus breakthrough pain medication as required. Debra had a chaotic approach to taking her medication. Whilst limiting the amount of medication prescribed to Debra at regular intervals would have reduced the amount she had access to at anyone time it cannot be established on the evidence that it would have prevented the overdose and her death.
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) A recommendation had been made by [redacted], Consultant Psychiatrist for regular prescriptions to be supplied (blisters) on a 3 days followed by a 4 days cycle. This would limit the amount of prescription medication available to her at anyone time. Debra Bates had a chaotic prescription pill use which appears to be fuelling her turbulence The dispensing pharmacist said that non blister pack 3 and 4 day prescription can be facilitated. These could be post dated to be collected on Tuesdays and Fridays for example. A task was sent to the practice pharmacist to discuss the case. The response was that 3 and 4 day prescriptions could cause confusion as double items would need to be added to the repeat prescription for each duration. This would result in more frequent deliveries and could cause issues. The regular prescriptions continued to be issued weekly (7 days) In evidence [redacted] said there would be a risk of over prescribing because by mistake a request for a 4 day prescription would be selected on the computer screen rather than a 3 day No further investigation or inquiries were made as to how other practices implemented this prescribing approach in a case where there are multiple medications (including controlled drugs) or whether / what safety measures are available on the computer system, to prevent / minimise the risk of the wrong prescription being requested
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 August 08, 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 [redacted] I have also sent it to [redacted] **NHS Derby & Derbyshire Integrated Care Board** 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: 28/06/2024** **Sarah HUNTBACH** **Assistant Coroner for** **Derby and Derbyshire**