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 Macklin Street Surgery, 90 Macklin Street, Derby DE1 1JX** **2 Daynight Pharmacy, 93 Macklin Street, Derby DE1 1JX** **3 The Secretary of State for Health and Social Care** **4 NHS Derby and Derbyshire Integrated Care Board**
1	**CORONER** I am Peter Nieto, senior 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 11 April 2024 I commenced an investigation into the death of Margaret Mary Feeney aged 78. The investigation concluded at the end of the inquest on 11 November 2024. The conclusion of the inquest was that: - Margaret died due to taking excess prescribed medication which she had become dependent on and addicted to. She had access to excess medication because of medical prescribing decisions and arrangements leading up to a bank holiday period.
4	**CIRCUMSTANCES OF THE DEATH** Margaret was found deceased at her home address on 1 April 2024 by her friend and cleaner. She had last been spoken to in a telephone call on 30 March 2024. Post-mortem examination with toxicology identified the medical cause of Margaret's death as the combined toxic effects of prescribed medication which she had taken in excess. She was also identified to have pneumonia which contributed to her death. A high total morphine level suggests the potential additional taking of a morphine-based substance. Margaret had a long history of being prescribed benzodiazepines and codeine, the latter medication for pain for diagnosed conditions. Unfortunately Margaret had become dependent on those medications and was recognised to overuse them. As a consequence, she was given seven-day prescriptions. On 26 March Margaret's friend was concerned that Margaret was confused, and the friend and Margaret attended a GP appointment that afternoon. The GP wanted to reduce Margaret's diazepam and issued a prescription for a lower dose in a daily dose blister pack. The codeine prescription was not altered. The new diazepam prescription was with Margaret on 27 March. This was the week prior to the Easter holiday period. Margaret had received her usual Monday prescription (25 March) including diazepam and codeine. With the new diazepam prescription received on 27 March Margaret had an excess of five days of that drug. Because of the pending bank holiday Margaret received an early prescription of codeine on 28th March, which meant she had four days excess codeine.

	Clearly, given her recognised dependence and overuse, there was a real and foreseeable risk that Margaret would take excess diazepam and codeine that was available to her between 27 March and her death. In addition to the toxicological evidence, when she was found deceased there were empty or near empty blister packs from the excess medication prescribed to her. On the evidence there is no reason to consider that Margaret had deliberately taken the excess medication to cause her own death.
5	**CORONER'S CONCERNS** 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:- I am concerned that measures are not in place at Macklin Street Surgery and Daynight pharmacy to prevent prescription of excess medication to patient's recognised to be at risk of overdose, either intentional or unintentional, who are ordinarily issued shorter period repeat prescriptions to reduce those risks. This situation arises when early prescriptions are issued due to statutory holiday periods when most pharmacies are likely to be closed. I have been informed that measures have been introduced to prevent excess prescribing by taking account of single day bank holidays, but there are no measures relating to longer bank holiday periods (e.g. Easter). With electronic patient record and data systems it seems a reasonable presumption that suitable solutions can be identified. As I imagine that the substance of my concern is likely to apply to other GP practices and pharmacies, I have also sent this report to the Department of Health and Social Care and NHS Derby and Derbyshire Integrated Care Board.
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 January 20, 2025. 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] (daughter) • [redacted] (son) • [redacted] (son) • Macklin Street Surgery 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: 25 November 2024**  **Peter Nieto** **Senior coroner for Derby and Derbyshire**