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 NHS England & NHS Improvement (PFDs)** **2 The Chief Coroner**
1	**CORONER** I am Anita BHARDWAJ, Area Coroner for the coroner area of Liverpool and Wirral
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 31 January 2024 I commenced an investigation into the death of Neil Michael YATES aged 53. The investigation concluded at the end of the inquest on 01 November 2024. The conclusion of the inquest was that Neil died of a Drug Related Death. The cause of death being: 1a Mixed Drug Toxicity, Bronchopneumonia II. Chronic Obstructive Pulmonary Disease, Cirrhosis
4	**CIRCUMSTANCES OF THE DEATH** Neil Michael Yates was a 53 year old gentleman who had a number of co-morbidities, including long QT syndrome. Neil also had a history of being a habitual heroin user. Whilst in the community Neil was prescribed MST (morphine sulphate tablets) instead of liquid morphine due to the risk of liquid morphine on his long QT syndrome. This was prescribed by a voluntary sector organisation specialising in substance misuse and criminal justice intervention projects in England and Wales. On being remanded into custody the GP records were reviewed by the prison GP, this medication change did not appear on his records and so liquid morphine was prescribed to him. This change did not cause or contribute to his death, however, during the inquest evidence was heard that when organisations, other than GPs, prescribe medications to individuals it takes a number of weeks before the information is sent to the GP surgery for it to be placed on the GP summary for that individual; thus posing a risk that further medication is prescribed to the patient without knowledge of what has already been prescibed.
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) The delay of information relating to what has been prescribed to an individual being sent to the GP surgery by voluntary and NHS organisations.

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 December 30, 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. [redacted] (sister) 2. HMP Altcourse (Practice Plus Group) 3. Newton-le-Willows Community Hospital (GP) 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: 04/11/2024**  **Anita BHARDWAJ** **Area Coroner for** **Liverpool and Wirral**