ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NHS England**
1	**CORONER** I am Charlotte Keighley, Assistant Coroner for the coroner area of Cheshire.
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 the 12th July 2023 I commenced an investigation into the death of Alexandra Bronte Roberts. Alex died on the 14th May 2023. She was 26 years old. The investigation concluded at the end of the inquest on the 17th December 2024 when the medical cause of death was confirmed as 1a Insulin Overdose.
4	**CIRCUMSTANCES OF THE DEATH** Alex had a long history of mental health issues and had a diagnosis of Type 1 diabetes, requiring daily injections of insulin. Alex had a history of self-harm and in August 2022, March 2023 and April 2023 she had attended hospital having intentionally overdosed on her prescribed insulin medication. Following the incident in April 2023, Alex was admitted to an acute Mental Health Ward on an informal basis from which she was discharged on the 10th May 2023. Alex was under the care of the Home Treatment Team and it was recognised at that time, that in order to mitigate the risk of overdose, Alex's medication should be prescribed for to her to collect every two to three days. This was done in respect of all of Alex's medication save for her insulin, which could only be prescribed in the form of pre-filled pens providing her with around ten days supply. The Court heard evidence in respect of the efforts that were made by those on the ground to limit the amount of insulin available to Alex at any one time. Consideration was given by the GP as to whether a junior pen could be prescribed in place of a standard pen, the evidence being that the amount of insulin in both the junior and standard pen is the same (300 units). The only difference between the two pens being how much insulin is released at any one time and therefore having no effect upon the overall amount of insulin available to be administered through repeated use. There was agreement from all involved in Alex's care that what was required was a restriction in the amount of insulin available to her. This was something easily done in respect of her other medication and, the Court heard, something which can be done

	with other medications, where arrangements can be made for the medication to be prescribed in smaller amounts. On the evening of the 13th May 2023, Alex took an intentional overdose of her prescribed insulin medication, the Court having heard evidence that she had taken all of the insulin in her prescribed pre-filled pens. She was found deceased the following day.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence 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:- 1. The minimum amount of insulin available to be prescribed at the time of Alex's death was 300 units, amounting to around 10 days of medication for Alex, enabling her to take a large overdose. The Court heard evidence that had it been possible to prescribe a smaller amount, the smaller amount would have been prescribed so as to reduce the risk of overdose.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 27th February 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:- The family of Alexandra Bronte Roberts Cheshire and Wirral NHS Foundation Trust I have also sent it to the Earnswood Medical Centre who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. 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	**DATE:- 2nd January 2025** **SIGNED BY CORONER:-**