Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Secretary of State Department of Health and Social Care**
1	**CORONER** I am Nigel PARSLEY, HM Senior Coroner for the coroner area of Suffolk
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 13th May 2024 I commenced an investigation into the death of **Kim Jeanette ROBINSON** The investigation concluded at the end of the inquest on 28th January 2025. The conclusion of the inquest was that the death was the result of:- **Suicide** The medical cause of death was confirmed as: **1a [redacted] toxicity**
4	**CIRCUMSTANCES OF THE DEATH** **Kim Robinson's death was recognised at 05:16 on 12th May 2024, at her home address in Suffolk.** **Kim had suffered for many years with chronic and debilitating leg and back pain, for which she took prescribed medication. Kim also suffered with her mental health and had previously taken overdoses of her prescribed medication.** **Toxicological analysis identified that Kim had the drug [redacted] in her system (an anxiety, heart and blood pressure medication) significantly above the toxic level.** **Kim was not prescribed [redacted] at the time of her death by her usual GP, but had obtained a supply from an on-line pharmacy.** **In order to obtain [redacted] on-line Kim ensured she supplied the required details, rather than her correct details. The process required to do this was described as a 'tick-box' exercise in court.** **When the online prescription was made (6th May 2024), the prescribing clinician had no access to Kim's online GP records.**

	Evidence was heard that had access to Kim's GP records been available to the prescribing clinician, the prescription of [redacted] would not have been made. **Evidence heard in court identified that Kim's normal prescriptions were secured by a loved one, who controlled the amounts of prescription medication Kim could access at any one time.** **When delivered, the package containing the [redacted] was addressed to Kim, providing her direct access to a fatal quantity of prescription medication.** **Had the online prescription not be made, Kim's death would not have occurred.**
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters given 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** as follows. – **1. Following Kim's tragic death the GP who had prescribed the prescription of [redacted] to Kim, reviewed the current online system in place and identified five areas where in his evidence he identified changes could be made.** **The GP stated there was:-** a) **The need for online prescribers to be able to access a patient's records (at least the Summary Care Records). These records could be attached to the consultation for review by the prescriber.** b) **All patients could be asked for consent to share the details of their prescriptions with their current GP and/or regular practitioner. When consent is given, it was suggested a notice should be sent to these healthcare providers at the same time the medicine is delivered to the patient. Without such consent, the patient's order should not be accepted.** c) **Prescribers could have the ability to add comments when reviewing a consultation, whether it is approved or vetoed.** d) **All consultations could include the question: "Have you ever had suicidal behaviour or thoughts?"** e) **Prescriptions could be also for smaller quantities, taking into account the possible lethal dose of the medicine. If necessary, dispensing should be limited to weekly or reduced frequencies.** **Had these features been present on the on-line system, the GP stated he would not have issued a prescription of [redacted] to Kim.** **In light of the evidence heard in this case I believe the current system of on-line prescription service needs to be reviewed.** **2. It is of note, that the matter of concern regarding the ease in obtaining online prescriptions was previously raised by this court on 15th November 2019 in a Prevention of Future Death report following the tragic death of Deborah Headspeath on 3rd August 2017.**
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken in order to prevent future deaths, and I believe you or your organisation have the power to take any such action you identify.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 28th March 2025 I, the Senior Coroner, may extend the period if I consider it reasonable to do so. 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. The other Interested Persons in this matter I am 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. She may send a copy of this report to any person who she believes may find it useful or of interest. You may make representations to me, the Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Dated: 31/01/2025**  **Nigel PARSLEY** **HM Senior Coroner for** **Suffolk**