

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Your Health Partnership Regis Medical Centre
1	CORONER I am Mrs Joanne Lees Area Coroner for the coroner area of The Black Country.
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. https://www.legislation.gov.uk/ukpga/2009/25/schedule/5 https://www.legislation.gov.uk/uksi/2013/1629/part/7
3	INVESTIGATION and INQUEST On 14/05/25 I commenced an investigation into the death of Danielle Monique Christina JONES. The investigation concluded at the end of the inquest on 1/10/25. The medical cause for the death of Danielle Jones was as follows; 1a Multidrug Toxicity II History of Depression, Drug Abuse The conclusion at inquest was Suicide.
4	CIRCUMSTANCES OF THE DEATH On 13/5/25 Miss Danielle JONES was found unresponsive at her home address and confirmed as deceased by attending paramedics. She was found in the bathroom by her partner. Miss Jones had a background of mental health problems, substance misuse, previous and recent (prescription) drug overdose. Post-mortem toxicology tests found evidence of High levels of amitriptyline along with excess zopiclone and recent substantial cocaine use. The Pathologist concluded she died from multi drug toxicity. The amitriptyline level was within the fatal range. The level of zopiclone was well above that expected from therapeutic dosage. I found she died from the combined toxic effects of a fatal level of amitriptyline along with an excessive amount of zopiclone.
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. Miss Jones had a background of substance abuse, previous and recent (prescription) overdose. Miss Jones self-disclosed overuse of GP prescribed Diazepam on 12th July 2023, 18th April 2024, and 13th June 2024. Miss Jones also reported depleted GP prescribed Zopiclone medication on 4th September 2024.
2. She had a telephone consultation with her GP on 24/2/25 where she disclosed an overdose of her prescription medication and had a further telephone appointment with her GP on 25/2/24 where she repeated the same information.
3. Miss Jones was being supported by Cranstoun Drug & Alcohol Service. Miss Jones attended for an appointment with Cranstoun on 21/2/25 where she confirmed that a recent tablet ingestion was a deliberate overdose attempt. Following that appointment the substance abuse nurse updated the GP practice via email GP updated via email correspondence of well-being concern following intentional overdose. It is unknown whether this communication was known to the GP who spoke to Miss Jones on 24th and 25th February 2025.
4. In any event, Miss Jones self-reported to her GP on both 24/2/25 and 25/2/25 that she had taken an excessive amount of her prescription medication 3 weeks previously. She reported that she had taken [REDACTED] but vomited afterwards.
5. Although Miss Jones was signposted to Mental Health Services by her GP, her prescription medications do not appear to have been reviewed and the GP surgery continued to prescribed repeat medications in large amounts at 28 day frequency without any further review subsequent to her appointment on 25/2/25.
6. She was issued with repeat prescriptions on 3 occasions subsequent to her appointment on 24th and 25th February 2025 when she self-disclosed an overdose of prescription medication.
7. On 6/3/25 despite a recent self-reported admitted overdose of prescription medication of [REDACTED]
[REDACTED]
[REDACTED]
8. On 27/3/25 despite a recent self-reported admitted overdose of prescription medication of [REDACTED] Miss Jones was prescribed
Amitriptyline [REDACTED], Diazepam [REDACTED] lamotrigine [REDACTED]
mirtazapine [REDACTED] pregabalin [REDACTED] **zopiclone** [REDACTED]
9. On 28/4/25 despite a recent self-reported admitted overdose of prescription medication of [REDACTED] Miss Jones was prescribed [REDACTED]
[REDACTED]
[REDACTED]
10. Miss Jones died on 13/5/25 from the combined toxic effects of a fatal level of **amitriptyline** along with an excessive amount of **zopiclone**.
11. The clinical lead at Cranstoun had previously had discussions with the GP about reducing Miss Jones prescription for zopiclone.
12. No medication review appears to have taken place after Miss Jones self-reported overdose of prescribed medication nor after concerns were raised by Cranstoun.
13. GMC Guidance requires a practitioner to prescribe drugs or treatment including repeat prescriptions, only when they have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs and to keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made.
14. There is no clinical rationale recorded for the continued prescribing of Miss Jones's repeat medications in terms of managing Miss Jones's risk of overdose given her recent disclosure e.g. reducing the frequency to 7 days rather than 28 days.
15. There is no evidence of any medication review having taken place after Miss Jones's disclosure of overdose of prescription medication or prior to her repeat prescriptions being issued on 6/2/25, 27/3/25 or 28/4/25. Her last reported medication review was on 23/8/24.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and 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 22/12/25. 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] [REDACTED] (Mother of the deceased). I have also sent it to Sandwell and West Birmingham NHS Trust. 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 other 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. 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 coroner, at the time of your response, about the release or the publication of your response.
9	27/10/25 [REDACTED]