	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive** **The Great Western Hospital** **Marlborough Road** **Swindon** **SN3 6BB**
1	**CORONER** I am Grant Davies, Area Coroner for Wiltshire and Swindon
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. http://www.legislation.gov.Uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 5 April 2024 I commenced an investigation into the death of Anna Maria Burns, a 37-year-old lady. The investigation concluded at the end of the inquest on 6 November 2025. The conclusion of the inquest was: Box 3 - Narrative Box 4 - Narrative - On 12th January 2024, at around 0930H, Anna received her prescribed medications including methadone, pregabalin and zopiclone. She was seen taking some medication on receipt, but the type and quantity remain unclear. She went to bed at approximately 1030H at 6 Ewden Close, East Wichel, Swindon, after reporting feeling tired not having slept for 2 days. She was last heard from during a telephone call which ended at 1130H. Anna was later found unresponsive at around 1630H. Emergency services were then called, and confirmed Anna was deceased at 16:36H. Anna had taken medication over her prescribed amount, but her intent remains unclear. I (a) Multidrug Toxicity (methadone, zopiclone and pregabalin) I(b) I(c) II

CIRCUMSTANCES OF THE DEATH

On the 12th January 2024 Anna Burns was seen to take some of her medications immediately after her father had obtained them, whilst she was temporarily staying at her father's address. Anna was known to both mental health services and dependency services (the latter being "Change Grow Live" (CGL)). Anna spoke to a PCLS representative between 11:00 and 11:30 that day by telephone but fell asleep, so the call was ended. There was nothing said during the call that would indicate Anna intended to or had taken any steps to take her own life. David entered Anna's room at 16:00 and noticed she was unresponsive and had stopped breathing. David called 999 at 16:15. Emergency services attended and attempted CPR but declared her deceased at 16:36 on the 12th January 2024.

[redacted]bottles of methadone therapy (Physeptone) were found, [redacted]. Other packets of prescribed medication (some of which were completely or partially empty) were also found. All medication packets and bottles been dispensed that day. Evidence from the toxicologists was such that she must have consumed more than her prescribed amounts of drugs (including methadone) given the post-mortem toxicology results, but it remains unknown as to precisely how or when.

Police confirmed there were no suspicious circumstances or third-party involvement.

Anna had significant medical and mental health issues, including overdosing and suicidal ideation. She was prescribed medication both by her GP and under CGL (6[redacted]). She previously changed GPs in December 2023.

Postmortem and toxicology confirmed that Anna had died of a mixed drug toxicity (see above), and that she had taken more than her prescribed dosages of those substances (one of which was methadone).

Before her death, Anna was admitted to Great Western Hospital (GWH) in November 2023, with a suspected opioid overdose. It is thought this was a self-referral. She was treated with naloxone at hospital and discharged 8 days later. Whilst a discharge summary for the opioid overdose was sent to the deceased (previous) GP, no such notification was sent to CGL, who were the prescribing authority for opiate replacement therapy. The deceased had a previous history of overdoses prior to November 2023.

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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 will 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 prescribing agency (for methadone) was unaware of the opiate overdose in November 2023 and the resultant hospital admission until the inquest, and after Anna's death.

(2) Whilst a discharge summary was properly sent to the (previous) GP, no such notice regarding the opiate overdose was sent to the opiate prescribing authority.

(3) Evidence was heard at the inquest that had the prescribing authority known of the opioid overdose in November 2023, they would have reviewed her case and likely would have put in place restrictive prescribing practices (such as lower or single daily doses, possibly supervised). It is also possible that they may have contacted the GP to warn them of the increased risk. Evidence was heard that not knowing of such an admission left the prescribing authority in a position of potentially approving inappropriate prescribing regimes (with risk of overdose in such cases).

(4) I did not find that GWH's were in any way obliged to send the discharge summary to the prescribing agency, and neither was such an omission causative or contributory to Anna's death. I did not find the prescribing regime was inappropriate, but it is possible that in other or future

	cases, a prescribing agency could be unaware that a patient had been treated for overdose at hospital and would therefore be unable to properly review the overdose risks to its patients in an informed way, and that future deaths may occur as a result. (5) It should be considered that notification to relevant parties (especially methadone prescribing authorities) regarding hospital admission for drug overdoses take place in the same manner as GP's highlighting the nature of the admission (i.e. overdose).

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and 1believe you, Chi f Executive of The Great Western Hospital, 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 14 January 2026. 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] (father) 2. Change Grow Live (CGL) 3. Avon & Wiltshire Mental Health Partnership NHS Trust (AWP) 4. [redacted] (Geneal Practitioner at Ridgeway View Family Practice, Swindon) 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.	Dated 19 November 2025 Signature [redacted] _____Grant Davies, Area Coroner for Wiltshire & Swindon