	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** (a) **Somerset NHS Foundation Trust** (b) **Taunton Road Medical Centre**
1	**CORONER** I am Vanessa McKinlay, Area Coroner for Somerset
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 19 January 2026 I commenced an investigation into the death of Peter Leech. The investigation concluded at the end of the inquest on 2 September 2026. The narrative conclusion of the inquest was: Mr Leech died from the respiratory complication of post-haemorrhagic epilepsy to which proton pump inhibitor medication made a contribution.
4	**CIRCUMSTANCES OF THE DEATH** Having considered medical evidence from [redacted] (Consultant Neurologist), [redacted](Consultant Neurosurgeon) and [redacted] (Specialist Registrar in Cardiology and Internal Medicine), the medical cause of death was determined to be: 1a Aspiration Pneumonia 1b Seizure 1c Dyselectrolytaemia 1d Proton Pump Inhibitor and Diarrhoea

	2 Post-haemorrhagic epilepsy Mr Leech had a history of seizures having had surgery to remove a brain tumour in 2024 which was complicated by a brain bleed. On 7 January 2026, Mr Leech had a seizure which was likely contributed to by an electrolyte disturbance secondary to proton pump inhibitor medication and a recent history of diarrhoea. He was admitted to Musgrove Park Hospital where he was found to have aspiration pneumonitis secondary to the seizure. Despite treatment, Mr Leech's condition deteriorated and he died in hospital on 11 January 2026. The evidence established that the proton pump inhibitor medication (Omeprazole) had been started during a hospital admission and continued by the GP practice. It was prescribed on a long term basis at a time when Mr Leech's history of epileptic seizures was well established.
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 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. – (a) The evidence established that proton pump inhibitor medication has a rare but recognised side effect of causing electrolyte disturbance and thereby lowering the threshold of risk of epileptic seizures (b) Mr Leech had a well-established history of seizures which had at times led to hospital admission (c) The proton pump inhibitor medication was started during an admission in one of the Trust's hospitals (d) No guidance was given to the GP about the duration of the prescription of this medication and the GP continued to prescribe it on a continuing basis (e) The GP's evidence was that he was not aware of the increased risk of seizure caused by the medication
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 28 October 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: (a) [redacted] (Mr Leech's wife) (b) [redacted] (Mr Leech's sister) I have also sent it to NHS England. 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. 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 by the Chief Coroner.
9	**2 September 2026** Signature: [redacted] **Vanessa McKinlay** **Area Coroner for Somerset**