REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NHS England, P O Box 16738, Redditch, B97 9PT** **2. NHS Sheffield Clinical Commissioning Group, 722 Prince of Wales Road, Sheffield, S9 4EU**
1	**CORONER** Donald Coutts-Wood, assistant coroner for the coroner area of South Yorkshire (West).
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. Schedule 5 to those Regulations provides: (1) Where— (a) a senior coroner has been conducting an investigation under this Part into a person's death, (b) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and (c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner must report the matter to a person who the coroner believes may have power to take such action. (2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it. (3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner.
3	**INVESTIGATION and INQUEST** On the 20th February 2012 I commenced an investigation into the death of Denise Sharon Parramore, who was born on the 19th December 1958. The investigation concluded at the end of the inquest on the 19th November 2013. The conclusion of the inquest was that Ms Parramore died on the 19th February 2012 at [redacted] Bradfield, Sheffield due to respiratory depression as a result of acute administration of Tramadol in excess of the level prescribed taken in the day prior to her death in combination with Benzodiazepines, Venlafaxine and Pregabalin.

4	**CIRCUMSTANCES OF THE DEATH** Denise Sharon Parramore had a lengthy history of mental ill health. She was first under the care of Psychiatric Services in Sheffield in 1999. In the ensuing years there were a number of serious incidents of self-harm, and repeated indications of suicidal thoughts. On the 13th December 2011 Denise Parramore took an overdose of prescribed medication. She was subsequently discharged by the relevant psychiatric team in January 2012 when it is understood her medication included Pregabalin, Venlafaxine and Benzodiazepines. She was due to have a further appointment with the home treatment team at the end of February 2012. Denise Parramore's General Practitioner had been prescribing Tramadol since September 2010, for chronic pain. Denise Parramore was found deceased on the 20th February 2012.
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. – (1) The Psychiatric Services, and in particular her Consultant Psychiatrist, was not aware, prior to Denise Parramore's death, of her being prescribed Tramadol by her General Practitioner. Concerns would have been raised, and action likely taken, if she had been aware. The Consultant Psychiatrist was not informed either by Mrs Parramore herself, nor the General Practitioner of the prescribing of the Tramadol. My concern is that there should be open, and constant two-way communication between those in primary care and secondary care such as in these circumstances. (2) For the same reasons as given above, will it be possible for those in primary and secondary care access each other's documentation, which would likely have revealed the prescribing.
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. Is there an intention for a National scoring system to be introduced, and indeed is consideration being given to the introduction of computerised systems that lead to automatic referral to the relevant senior doctor?
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 11th August 2014. 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. Howells LLP (Representing the family) 2. BLM Law (Representing [redacted] 3. Nabarro LLP (Representing [redacted] 4. Sheffield Health and Social Care 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	**19th May 2014**