REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Roundwell Medical Centre** **25-27 Dr Torrens Way** **Costessey** **Norwich** **NR5 0GB**
1	**CORONER** I am JACQUELINE LAKE, senior coroner, for the coroner area of Norfolk
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 15th August 2013 I commenced an investigation into the death of KATHRYN LOUISE SAWYER, 33 years. The investigation concluded at the end of the inquest on 8th APRIL 2014. The medical cause of death was Respiratory failure due to overdose of Methadone in combination with therapeutic levels of other drugs. The conclusion of the inquest was Accidental overdose of prescribed medication.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Sawyer had a significant history of mental health issues. She was prescribed Chloral Betaine in 2003. She was prescribed Methadone in 2011 following an addiction to Codeine. Mrs Sawyer was seen regularly at her GP surgery and by Mental Health Services. At the time of her death Mrs Sawyer was prescribed a number of different medications. Mrs Sawyer was very knowledgeable about medication and regularly requested increases. On 14th August 2013 Mrs Sawyer was found collapsed and unresponsive at the bottom of a flight of stairs in the communal hallway at her home address. She was found by a neighbour who called the ambulance service. Mrs Sawyer was transferred to Norfolk & Norwich University Hospital where she died shortly after arrival.
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) Mrs Sawyer registered with the Roundwell Surgery in July 2012 at which time she was known to be addicted to Chloral Betaine (she was prescribed double the dosage recommended in the BNF) and was prescribed a number of different additional medications, including Methadone (prescribed by Trust Alcohol and Drug Service);

	(2) She attended the Surgery with a letter from her previous GP expressing Mrs Sawyers' concerns about her medication being decreased. It was felt sensible to allow her to feel comfortable with the Surgery before consideration was given to the medication and amounts she was being prescribed. This is accepted as reasonable. (3) During the course of the next 13 months Mrs Sawyer was seen by the Practice on a regular basis when her medication was varied and/or increased. She was admitted to Hospital in November 2012 as a result of an overdose. (4) Mrs Sawyer's mental health condition stabilised in Spring 2013 when she attended the Surgery for physical problems only. (5) Her medication was not reviewed by the Surgery until June 2013. It was then reviewed by a Locum Doctor. There is no or no detailed record of the discussion relating to her medication and no plan made between patient and the surgery with regard to future medication and in particular any plan to decrease.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 11 June 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: Chief Executive Norfolk & Suffolk NHS Foundation Trust Hellesdon Hospital Drayton High Road Norwich NR6 5BE [redacted] 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	**16 April 2014** Yvette.