ANNEX A

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:
	Chief Executive Royal Orthopaedic Hospital NHS Foundation Trust 3.
1	CORONER
	I am Geraint Urias Williams, Senior Coroner, for the coroner area of Worcestershire
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 10 th October 2014 I commenced an investigation into the death of Leonardus Adrianus Gerardus VRIES then aged 48 years.
	The investigation concluded at the end of the inquest on 4 th March 2015. The conclusion of the inquest was accidental death the medical cause of death being 1(a) respiratory depression, 1(b) combined toxicity of bupivacaine and morphine and diamorphine.
4	CIRCUMSTANCES OF THE DEATH
	Mr Vries apparently acquired medical grade drugs from his place of work and used them to inject himself at his family home where died.
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. –
e e de de de la companya de la comp	(1) It appeared in the evidence given by that there were significant documentary failings in the control of medication at the Royal Orthopeadic Hospital. Specifically he said that there was no audit or any paper trail of the use of non-controlled medication. With regard to controlled medication it was accepted that there were documentary deficiencies which meant it could not be precisely ascertained what controlled medication had been taken or used or administered to patients.
are the state of t	Whilst the control of controlled medications appears to have been addressed by way of training and increased scrutiny and audit procedures confirms that there is still no audit of non-controlled medication. Specifically he said that when stocks of non-controlled medication are delivered to wards and departments there is no check as to who uses the medication or for what purpose.

***	It appears to me therefore that there is a significant opportunity for the abuse or theft of non-controlled medication.
***************************************	told me that the hospital were acting in accordance with the Department of Health guidelines in the matter and that unless the Department of Health issued further guidelines there would be no change in this process.
	I suggest that the Trust needs to consider putting in place its own audit guidelines to ensure that what described as a "hole" in control measures is addressed. (2) (3)
6	ACTION SHOULD BE TAKEN
- Annual Control	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 25 th May 2015 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
	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	Signed
	G U Williams 9th day of March 2015 H M Senior Coroner