REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Ivy Grove Surgery, Derbyshire** **2. The Chief Executive, Derbyshire Community Health Services (DCHS)**
1	**CORONER** I am Dr Elizabeth Didcock, Assistant Coroner, for the Coroner area of Nottinghamshire
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 the 28th February 2015, I commenced an investigation into the death of Kymberley Holden, aged 27 years. The investigation concluded at the end of the inquest on the 23rd March 2017. The conclusion of the inquest was a Narrative as follows: On the 26th November 2014 Kymberley Holden died from Oxycodone toxicity. This drug had been prescribed for pain arising from her neurological condition. The dose prescribed for her, was significantly higher than intended, and contributed to her death.
4	**CIRCUMSTANCES OF THE DEATH** Kymberley had a chronic neurological condition, that of Devics Disease, similar to Multiple Sclerosis. She was under the care of the Neurology team at Derby Hospitals NHS Trust. She suffered with chronic pain. Her GP prescribed a dose of a strong Opiate, Oxycodone, for pain, at a concentration that was 10 times the intended dose. An alert on the prescribing screen, advising that the medication was a concentrated solution was overridden. The suggestion to prescribe this medication, which was used rarely in general practice, came from a Specialist Nurse working for a different Health Trust, that of Derbyshire Community Health Services. This nurse did not discuss her suggestion of Oxycodone with the Hospital team, who were advising on all other medications. Further detail of my findings in relation to these issues is included in the written judgment in this case, which is attached to this document. .
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 therefore my statutory duty to report to you. Essentially the serious and outstanding matters of concern are as follows: 1. The continuing risk of unsafe prescribing of controlled drugs by the Ivy Grove Surgery, and the limited understanding of the duty to report serious prescribing incidents. 2. The continuing risk of poorly coordinated management and prescribing in neurological patients under the care of both DCHS and the Derby Hospital

	During the Hearing, I heard evidence in relation to these matters, and the oral evidence and documents went some way to addressing the concerns raised.
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 the 1st June 2017. 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. For the avoidance of doubt, I will require a response from Ivy Grove Surgery to 1) above, and from the DCHS in relation to 2) However, respondents are at liberty and encouraged to respond to all of the issues raised. Respondents may consider it advantageous to consider some of these issues jointly as well as individually. Should respondents favour supplementing their individual responses to all the above issues with a joint response, such a collaborative approach would be greatly welcomed but there is of course no obligation to do so.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted] Kymberley's father 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	**4th April 2017** **Dr E A Didcock**