REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mr Uday Bose** **Chief Executive** **Boehringer Ingelheim Limited** **Ellesfield Avenue** **Bracknell** **Berkshire RG12 8YS**
1	**CORONER** I am **PENELOPE SCHOFIELD**, senior coroner, for the coroner area of **WEST SUSSEX**
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 11th December 2018 I commenced an investigation into the death of **George Benjamin RIMMER** , aged 46. The investigation concluded at the end of the inquest on 1st August 2019, The conclusion of the Inquest was that Mr Rimmer died from an **accidental overdose of the pain relief medication Oramorph.**
4	**CIRCUMSTANCES OF THE DEATH** Mr Rimmer had been suffering with excruciating back pain for many years. This led to him having decompression surgery on 1st August 2018 following which he was prescribed Oramorph along with other pain relief medication. When discharged from hospital his prescription for Oramorph was changed for use to help with breakthrough pain. The prescription at that time was 5ml (containing 10mg Morphine) with the dose being spread out at every three to four hours. On 25th October 2018 Mr Rimmer was found deceased at his home address. Following a post mortem examination the pathologist gave a cause of death as **Fatal Opiate Intoxication**.
5	**<u>CORONER'S CONCERNS</u>** 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) Mr Rimmer was known to swig out of the bottle rather than take a measured dose as many patient do; (2) Mr Rimmer self medicated as required; (3) Mr Rimmer's GP did not recall advising him of the possible consequences of exceeding the prescribed dose. (4) There was **no evidence to show that anyone had counselled Mr Rimmer** with regards to the use of this drug. (5) The leaflet that comes with the bottle does not provide a **sufficient warning** of the dangers of taking an excess dose. (6) The is no mention of the **dangers of drinking from the bottle** and not measuring the dose. (7) There is **no warning on the bottle** to act as a reminder of the dangers of taking an excess dose or of the culmative effect of taking more than the prescribed amount.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation 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 by11th October 2019. 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:- **The family of George Benjamin Rimmer** [redacted] **CQC** 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	**16th August 2019**  **Penelope Schofield, Senior Coroner**