ANNEX A

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:** **Mid Essex CCG Trust** **NHS England** **Minister of Health** **Fern House Surgery**
1	**CORONER** I am Caroline Beasley-Murray, Senior Coroner, for the Coroner area of Essex
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 26th May 2019 I commenced an investigation into the death of Joanna Clare Alice Flynn. The investigation concluded at the end of the inquest on 14th November 2019. The conclusion of the inquest was: - **The deceased suffered from a number of long standing medical conditions. It is not possible to arrive at an ascertained medical cause of death nor a conclusion other than an Open conclusion. This is set against a background of long standing prescribed opiate addiction.**
4	**CIRCUMSTANCES OF THE DEATH** The deceased, a 31 year old lady with a long-standing history of hoarding medication, had last been seen on the 23rd May 2019. On the 26th May 2019, the deceased was found slumped over the side of her bed. The pathologist provided 1a) Unascertained, as the cause of death. Only possible medical causes were oxycodone toxicity, positional asphyxia and pneumonia.
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. – The General Practitioner who gave evidence told the court that there was a lacuna in the healthcare provided for patients such as the deceased in terms of giving assistance for weaning off addictive prescription drugs such as opiates. It was clear that General Practitioner's require highly specialised assistance in order to help such patients and agencies within the healthcare system to which to refer them. This was all lacking in this particular sad set of circumstances. The court was informed about a proposed pilot scheme – a substance misuse Locally Enhanced Service for people with dependence to prescribed opiates. There was no assurance that this had commenced or indeed yet been funded. I would like an assurance that this hopeful initiative has got off the ground and indeed I would like to have information about any other initiatives to endeavour to address this dreadful problem. I would also like to hear what strides have been taken to improve training and education for general practitioners and GP practices in this worrying area of care.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 by 31st January 2020. 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- Solicitors for [redacted] Ms Flynn's family 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	**14th November 2019** **Caroline Beasley-Murray**