Signed by Geoffrey Sullivan
Title Senior Coroner
Jurisdiction Hertfordshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Sir Simon Stevens - Chief Executive NHS England**
1	**CORONER** I am Geoffrey Sullivan Senior Coroner for **Hertfordshire**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 19/09/2019 I commenced an investigation into the death of Peter COLE. Following a post mortem and toxicology analysis the cause of death provided was: 1a) Drug Overdose II) Ischaemic Heart Disease The investigation concluded at the end of the inquest 27th February 2020. The circumstances of the death recorded: On 14 August 2019 Peter Cole was found collapsed at his home address by a neighbour. He was unresponsive and CPR was started which was continued by ambulance crew and a return of output was achieved. Peter was transported to Lister Hospital where a CT chest showed bilateral lower lobe collapse/consolidation and multiple rib fractures from CPR. Following discussion with family, doctors decided no further resuscitation would be given and Peter died later that day. The conclusion of the inquest was: Prescription Drug Related
4	**CIRCUMSTANCES OF THE DEATH** Mr Cole was an older person with a diagnosis of dementia. He was in receipt of numerous prescription drugs, on repeat prescription. One of the drugs he was receiving was Tramadol, on a repeat prescription of 100 capsules per month over an extended period. The drug upon which he overdosed was Tramadol. I did not find a probable contribution to Mr Coles death as a result of the large quantity of repeat prescription drugs but heard that he had amassed a large quantity of prescription medication that he was simply not taking and was building up in his house. As a result of concerns raised about the extent of the drugs prescribed to him, I heard evidence from an experienced Mental Health Nurse. She outlined in her evidence that Mr Coles' case was far from unusual. That she frequently visited patients who had amassed vast quantities of unused medication and medical supplies. Often these patients were older and with varying degrees of mental impairment. These drugs were invariably on repeat prescription and the continued need for the drugs and/or compliance with the prescribed regime was not adequately supervised. One patient had a 'cupboard full' of unused medication.

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) That repeat medication is not being adequately monitored, leading to many (often older and/or mentally infirm) patients building-up dangerous quantities of prescribed medication. (2) That the inadequate supervision of prescribed (repeat) medication is so widespread that the consequent waste of resources has an adverse impact on the overall provision of healthcare. (3)
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Sir Simon Stevens, Chief Executive NHS England, 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 27 April 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 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	28/02/2020 Signature_____ Geoffrey Sullivan Senior Coroner Hertfordshire