Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 ULH NHS Trust Legal Services**
1	**CORONER** I am Paul COOPER, HM Assistant Coroner for the coroner area of Lincolnshire
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 08 February 2023 I commenced an investigation into the death of Lilian Margaret BOARD aged 91. The investigation concluded at the end of the inquest on 05 October 2023. The conclusion of the inquest was that: The deceased died on 1st February 2023 at Lincoln County Hospital, Greetwell Road, Lincoln after intentionally ingesting [redacted] tablets the day before. A note of intent was left.
4	**CIRCUMSTANCES OF THE DEATH** 91 years old who lived alone, no carers but had friend and family for support, the deceased has a known history of Depression, T2DM, Heart failure and was under geriatric team for worsening mobility. Family report that on 31.01.23 the deceased had taken possibly [redacted] (prescribed by GP), she had contacted a friend and told them she had taken the medication, friend has then subsequently called family who attend the property and find the deceased slumped by her bedside with a glass of water and empty blister packs, the deceased was unresponsive emergency services attended and admitted the deceased to LCH where she presented to A/E after taking fatal overdose [redacted]. She had written a letter for family saying that she wants to end her life. Had respiratory arrest for which she received Flumazenil boluses (5 in total) after which she was kept in A/E resus and started on Flumazenil infusion. ITU was involved and she was able to maintain her airway so planned to keep in resus. Her GCS was 15 after Flumazenil but remained drowsy. She was also started on iv antibiotics for clinical suspicion of aspiration pneumonia. Infusion was later stopped after covering for half life of zopiclone of 8 hours. She was then moved to MEAU on 1.2.23 where she became drowsy again and had stat dose of Flumazenil. Was later reviewed by consultant and started on EOL care after discussion with family. She passed away on 1.2.23. [redacted] at Lincoln County Hospital can provide a cause of death: 1a [redacted] toxicity Spoken with family who are aware that an Inquest maybe required given the history, they do not have any concerns regarding care or treatment, have requested for family to provide the letters which were left by the deceased. family were present and seen the deceased at LCH.
5	**CORONER'S CONCERNS**

	During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) The deceased was prescribed [redacted] by her GP. Following discharge from hospital on 18th January 2023 LCH also prescribed [redacted]. The deceased therefore had two prescriptions of the same medication that she used to end her life. Are there any checks in place to avoid duplicity of prescriptions between hospital and GP ?
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 November 30, 2023. 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 have also sent it to **ULH NHS Trust Legal Services** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 05/10/2023** Paul S. Cooper **Paul COOPER** **HM Assistant Coroner for**

	Lincolnshire