Regulation 28: Prevention of Future Deaths report

Frances Ann NEWBURY (died 20 May 2023)

	THIS REPORT IS BEING SENT TO: **1. Chief Executive** **London Ambulance Service NHS Trust** **220 Waterloo Road** **London** **SE1 8SD**
1	**CORONER** I am: Coroner Melanie Sarah Lee Assistant Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, Regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 9 June 2023 an investigation was commenced into the death of Frances Ann Newbury aged 61 years. The investigation concluded at the end of the inquest on 10 November 2023. The medical cause of death was 1a. Acute polydrug toxicity ([redacted]); 1b. substance misuse disorder; 2. chronic lung disease. The conclusion of the inquest was drug related.
4	**CIRCUMSTANCES OF THE DEATH** Frances Newbury was found unconscious and not breathing by her partner on the morning of 20 May 2023 at their home address. London Ambulance Service was called at 09:04 and arrived at 09:09. Ms Newbury's partner reported to the attending paramedics that she had taken [redacted] at approximately 21:00 the evening before. Ms Newbury had a long history of drug abuse, [redacted]. At post-mortem she was found to have 'popping' scars on the anterior and posterior aspects of both thighs and on both shins.

	Toxicology examination found [redacted] in her system. During ALS resuscitation attempts, paramedics inserted an igel, used a LUCAS2 device, inserted an intraosseous needle into her left tibial plateau and administered 10 doses of adrenaline, sodium chloride and intravenous glucose.
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. Despite paramedics being informed that Ms Newbury had taken illicit drugs the previous evening (albeit the report being of [redacted]) and obvious signs of 'popping' scars on her legs from [redacted], Naloxone was not administered. Although in Ms Newbury's case, it would have made no difference, I am concerned that in another case it may. This is not the first inquest in which I have queried why Naloxone has not been administered to patients (with a opiate misuse history) when all other potential reversible causes have been treated.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that your organisation has 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 5 January 2024. 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 following. • [redacted], Partner of Francess Newbury • HHJ Thomas Teague QC, the Chief Coroner of England & Wales 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 other 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.
9	**DATE** 10 November 2023 **SIGNED BY ASSISTANT CORONER**