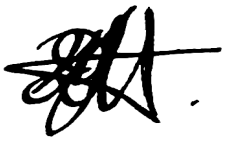
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Rt Hon Victoria Atkins, Secretary of State for Department of Health and Social Care** **2 [redacted], Chief Executive NHS England** **3 [redacted], Chief Executive James Paget University Hospitals NHS Trust** **4 [redacted], Rosedale Surgery Lowestoft**
1	**CORONER** I am Darren STEWART OBE, HM Area Coroner for the coroner area of Suffolk
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 07 October 2022 I commenced an investigation into the death of Sarah Julie MITCHELL aged 41. The investigation concluded at the end of the inquest on 27 November 2023. The conclusion of the inquest was that: Drug related The medical cause of death was confirmed as: 1a Toxicity of Multiple Drugs, including Morphine, Promethazine, Gabapentin, Fluoxetine 1b 1c 2 Fatty Liver
4	**CIRCUMSTANCES OF THE DEATH** Sarah Julie MITCHELL suffered from chronic back pain for over 15 years and struggled to manage this as well as the addictive effects of the pain medication she was prescribed to alleviate her pain. During the 12 years prior to her death she had made several attempts to reduce her pain medication in conjunction with her GP. The debilitating affects of her condition had also negatively impacted on her mental health and she suffered from periodic bouts of low mood and depression for which she was prescribed medication to help alleviate the symptoms. In the two years leading up to her death, Ms. MITCHELL self medicated, using dosages of her medication in excess of the prescription. She was known to hoard her prescription medication. This resulted in several overdose events where Ms. MITCHELL required ambulance attendance and hospitalisation. Following these overdose events, her GP reduced Ms. MITCHELL's prescription requiring her to attend daily to receive her medication. This would be increased to weekly following a period of compliance and due to the hardship Ms. MITCHELL experienced having to collect medication on a daily basis. On the 3rd August 2022, in the early morning (00.13 hours), Ms. MITCHELL was admitted

	to the James Paget University Hospital A&E Department having been involved in a Road Traffic Collision. Police had brought Ms. MITCHELL to hospital and there was a concern that she had taken an overdose of Gabapentin, one of her prescribed medications. Ms MITCHELL was discharged that morning with 14 days of medication. At the time Ms. MITCHELL was being prescribed her medication on a weekly basis due to concerns relating to her risk of overdose. In the early evening of the 3rd August 2022 (18.28 hours) Ms. MITCHELL was re-admitted to the James Paget University Hospital following a suspected overdose. She was seen by Mental Health Liaison Staff and assessed as not having suicidal ideation or intent, but having a high risk of accidental death due to overdose from self-prescribing. Ms. MITCHELL was discharged on the 4th August 2022 with a further 14 days of medication provided. The cumulative effect of the provision of 14 days medication on each of her two discharges meant she received 28 days worth of prescribed medication in less than a 48 hour period. Her weekly medication prescriptions from her GP continued meaning that Ms. MITCHELL had further opportunities to hoard her prescription medication. Ms. MITCHELL took a further overdose on the 11th August 2022 and was admitted again to the James Paget University Hospital in the late evening (23.48 hours) and she underwent a further Mental Health assessment the next day (12th August 2022) by Mental Health Liaison staff. Ms. MITCHELL expressed remorse as to her actions and she was again assessed as not having suicidal ideation or intent. She was assessed as being at high risk of accidental death from overdose. She was on weekly prescriptions for her medication at this point. A referral was made for further Mental Health Services support/treatment and at the time of her death she was pending an appointment scheduled for the following week. Ms. MITCHELL was found deceased at her residence on 22nd September 2022. Police enquiries revealed no suspicious circumstances or third party involvement. Post mortem examination found that Ms. MITCHELL had died from Multiple drug toxicity of prescribed medication. Pregabalin, a medication she was not prescribed at the time was also detected, although not at a fatal concentration.
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 provision to Ms. MITCHELL of 28 days' worth of prescribed medication in less than a 48-hour period (14 days' worth of medication dispensed on each occasion she was discharged hospital on the 3rd and 4th of August 2022). This occurred at a time when, due to concerns about Ms. MITCHELL hoarding medication and taking an overdose, she was receiving weekly medication prescriptions from her GP to control this risk. The evidence heard at Inquest indicated that there was no process in place whereby accident and emergency staff could access Ms. MITCHELL's medical records detailing the medication she was receiving and the rationale behind the dispensing regime in place.
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 March 04, 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 Chief Coroner and to the following Interested Persons [redacted] I have also sent it to **Norfolk and Suffolk NHS Foundation Trust** who may find it useful or of interest. 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	**Dated: 08/01/2024**  **Darren STEWART OBE** **HM Area Coroner for** **Suffolk**