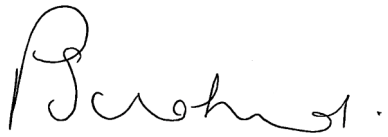
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive NHS Sussex Integrated Care Board Wicker House High Street Worthing BN11 1DJ
1	**CORONER** I am Penelope Schofield , Senior Coroner, for the coroner area of West Sussex and Brighton and Hove
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 22nd December 2022 I commenced an investigation into the death of Susan Mary Young aged 57 . The investigation concluded at the end of the inquest on 31st January 2024. The overall conclusion of the inquest was a narrative conclusion which stated that "Susan Mary Young died from an accidental ingestion of prescribed co-codamol tablets."
4	**CIRCUMSTANCES OF THE DEATH** On 20th December 2022 Susan died at her home address at [redacted] West Sussex. Susan had been feeling unwell and had been prescribed antibiotics for an ear infection and co-codamol tablets as pain relief. Sadly due to the pain she was in Susan took too many tablets over a short period of time and this led to a fatal toxicity. There was no evidence that this was a deliberate act to end her life
5	**CORONER'S CONCERNS** During 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: The possible toxicity from the Co-codamol tablets was not a considered by the ambulance crew who attended to Mrs Young following a 999 call. The Ambulance Service was not aware that Mrs Young had recently been prescribed Co-Codamol as the Ambulance service does not currently have access to GP records. There was a short period of time in which the Naloxdone antidote could have been given and evidence was heard from the expert at the Inquest that if the toxicity had been recognised earlier and Naloxodone administered there was a good chance that Mrs Young would have survived. As the Ambulance Service did not have the GP records readily

	available to them this meant that there was a missed opportunity to treat Mrs Young appropriately.
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 4th April 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:- **a) The family of Susan Young** **b) South East Coast Ambulance Service NHS Foundation Trust** **c) Bognor Medical Centre** 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: 09/02/2024**  **Penelope SCHOFIELD** **Senior Coroner for** **West Sussex, Brighton and Hove**