**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS**

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br>**THIS REPORT IS BEING SENT TO:**<br><br>The Chief Executive, Nottinghamshire Healthcare NHS Foundation Trust |
| 1 | **CORONER**<br><br>I am Miss Sarah Wood, Assistant Coroner, for the coroner area of Nottinghamshire. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On the 6th of June 2023, I commenced an investigation into the death of James Southern. The investigation concluded at the end of the inquest on the 2nd of October 2024.<br>The conclusion of the inquest was drug related death. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Jimmy died on the 31st of May 2023. He was found unresponsive by his father at his home address in Nottinghamshire. Jimmy suffered with pain and anxiety since his motorbike accident in 2002, and at times in order to cope, was known to self-medicate. There was an elevated reading of [redacted] and [redacted] at the time of death, which was the direct cause of death. Jimmy died from a polydrug toxicity.<br>He was receiving care from Nottinghamshire Healthcare Trust following a discharge from Highbury Hospital, Nottingham. However, he wasn't seen by the services in the months leading up to his death.<br>The investigation and inquest identified there were errors in his records which misled medical practitioners and Jimmy into thinking a care coordinator had been allocated. There was also evidence that the records had not been uploaded in a timely manner and at times after death. There was also evidence that records were amended after death. Jimmy's case was not transferred to another care coordinator when his care coordinator was absent. This meant Jimmy was left without care in the months leading up to his death. |
| 5 | **CORONER'S CONCERNS**<br><br>During the course of the inquest the evidence revealed a matter 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.<br><br>The **MATTER OF CONCERN** is as follows –<br><br>• That there remain potential issues of poor record keeping. |

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| | • There are concerns over the level of communication between professionals within the Trust and communication with patients.<br><br>In my opinion, action should be taken to prevent future deaths and I believe you have the power to take such action. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion, action should be taken to prevent future deaths and I believe you have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by the 29th of November 2024. I, the Coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:<br><br>1. [redacted], Jimmy's mother<br>2. The Nottinghamshire Healthcare NHS Foundation Trust<br>3. [redacted]<br><br>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.<br><br>I may also send a copy of your response to any person who I believe may find it useful or of interest.<br><br>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.<br><br>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 | **4th of October 2024 Miss Sarah Wood** |