# Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

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| | **REGULATION 28 REPORT TO PREVENT DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**Chief Executive**<br>**James Paget University NHS Foundation Trust,**<br>**Gorleston,**<br>**Norfolk,**<br>**NR31 6LA** |
| **1** | **CORONER**<br><br>I am, Yvonne Blake, Area Coroner for the coroner area of Norfolk |
| **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 03 September 2024 I commenced an investigation into the death of Susan Nora Elizabeth YOUNG aged 63. The investigation concluded at the end of the inquest on 07 May 2025.<br><br>**The medical cause of death was:**<br>1a) Cardiac Arrest<br>1b) Mixed Overdose (Including [redacted])<br>1c)<br>2)<br><br>**The conclusion of the inquest was:**<br>Miss Susan Young suffered various cardiac problems, including a previous heart attack. She was also prescribed a medication for epilepsy which has the side effect of prolonging the Q.T. interval in the heart rhythm and can precipitate cardiac arrhythmias. Miss Young was found deceased in bed by nursing staff. |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br>Miss Young was admitted to hospital on 23 August 2024, having taken an overdose of prescription medication. This was not her first overdose. She was prescribed amongst others [redacted] which has the effect of prolonging the Q wave, the heart rhythm. She had taken an overdose on the 22 August 2024. When this had not succeeded taken another on 23 August 2024. She was monitored appropriately whilst in the emergency department and transferred to a ward with directions that she be attached to cardiac monitoring. When nursing staff took her to the ward, they did not give any handover and certainly no instructions about cardiac monitoring.<br>Miss Young was found unresponsive and not attached to any monitoring. Resuscitation failed.<br>It is thought that the medication may have had a cumulative effect.<br>When the nurses were packing up her belongings, they found more unused medication which had been left with the patient. It is not known if she had taken any of this. |
| **5** | **CORONER'S CONCERNS**<br><br>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. |

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| | The **MATTERS OF CONCERN** are as follows:<br><br>NO clinical handover to receiving ward. No instructions passed on from the doctor re cardiac monitoring. Patients own medication found in her belongings which had been with her, after her death allowing her the opportunity to take another overdose. |
| **6** | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 20 August 2025. 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>**The Family of the deceased.**<br>**Royal College of Nursing.**<br><br>I have also sent it to<br><br>**Department of health and Social Care**<br>**Care Quality Commission**<br>**Health Services Investigations Body**<br>**Healthwatch Norfolk**<br>**NHS England & NHS Improvement**<br><br>who may find it useful or of interest.<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** | **Dated: 24 June 2025**<br><br>**Yvonne K Blake**<br>**Area Coroner**<br>**Norfolk Jurisdiction**<br>County Hall<br>Martineau Lane<br>Norwich<br>NR1 2DH |