David Place
Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Care UK and their Solicitors**
1	**CORONER** I am David Place, His Majesty's Senior Coroner for the City of Sunderland
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 27th January 2025 I commenced an Investigation into the death of Mr Thompson Elliott, who died in Sunderland Royal Hospital, Sunderland on 24th January 2025 aged 83 years. The Investigation concluded at the end of the Inquest on 9th October 2025. I gave a narrative conclusion 'From respiratory failure having contracted influenza A whilst in hospital having been successfully treated for an overdose of his opioid medication.' The medical cause of death was: - Ia Respiratory Failure secondary to Influenza II Metastatic Lung Cancer
4	**CIRCUMSTANCES OF THE DEATH** Thompson Elliott became a resident at a care home on 6th December 2024. Mr Elliott was admitted to Sunderland Royal Hospital on 12th December 2024 with chest pains. He was discharged back to his care home on 18th December 2024 with new analgesia medication. On 20th December 2024 Mr Elliott was given a combination of his old and new opioid medication due to uncertainty in the care home as to which applied, as his discharge letter could not be located. Mr Elliott was then readmitted to Sunderland Royal Hospital due to the opioid overdose. Whilst in hospital he contracted influenza A having been successfully treated for the opioid overdose, but he did not have the physiological reserves to fight the virus due to his frailty and underlying malignancy.

5 **CORONER'S CONCERNS**

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.

The **MATTERS OF CONCERN** are: –

The evidence has revealed significant concerns with regard to the recording and administration of medication, when patients return to the care home, and a discharge letter cannot be located following a period in hospital.

I am concerned that the evidence was that if a patient returned to the care home with new medication prescribed whilst in hospital to replace previously prescribed medication, and the patient's discharge letter could not be immediately located, there would be uncertainty amongst staff as to the correct procedure to follow in such circumstances.

Medication that had been stopped whilst in hospital due to its impact upon the patient's kidneys continued to be administered on 18th and 19th December 2024, before it could be clarified with either the hospital or GP which was the correct medication. The new medication was not administered on either of those days.

The evidence revealed that the new medication was not immediately recorded onto the patient's electronic medication record (EMAR) and held in a cupboard pending clarification. Despite no clarification and following a 24-hour delay, it was then incorrectly added to the record as new and additional medication - not replacement medication.

The medication had been changed to oxycodone due to the impact oramorph was having upon the patient's kidneys. Due to the administration error in recording oxycodone as new and therefore additional medication, the patient was then given both oramorph and the new oxycodone medication on the morning and afternoon of 20th December 2024 which was 2 days following his discharge. This resulted in an opioid overdose.

I am concerned that the evidence was such that it was not possible to determine exactly what efforts, if any, were made by staff to clarify the medication position with the hospital on either 18th, 19th or 20th December 2024 but medication continued to be administered. On 21st December 2024 a team leader was able to speak to the hospital and despite being advised that if there was no discharge letter to take all medications and clarify the position with the GP, a decision was made to only administer the old medication of oramorph and there no attempts to contact the GP. There were no attempts to contact 111 or Recovery at Home for advice.

I am concerned that the evidence revealed that there was no policy or guidance document setting out the procedures, which staff must follow in such circumstances, which created confusion and inconsistent decision making resulting in a medication overdose and continued use of a medication that had been stopped in hospital due to the harm it was causing to the patient's kidneys.

The evidence raises a further concern that the procedure still remains unclear despite internal reviews following the death.

I shall be glad to be told of any learning arising from this death and timescales and results of your review.

6	**ACTION SHOULD BE TAKEN** 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** You are under a duty to respond to this report within 56 days of the date of this report, namely by 11th December 2025. 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: - • Family • South Tyneside and Sunderland NHS Foundation Trust • Care Quality Commission 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 this 15th day of October 2025 Signature: [redacted] HM Senior Coroner for the City of Sunderland