MS N J MUNDY
H M CORONER
SOUTH YORKSHIRE (East District)

email: [redacted]

CORONER'S COURT AND OFFICE
CROWN COURT
COLLEGE ROAD
DONCASTER DN1 3HS

[redacted]

Date: 4 December 2025

[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: NHS South Yorkshire Integrated Care Board
CORONER

1 I am Abigail Combes for South Yorkshire East

CORONER'S LEGAL POWERS

2 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

INVESTIGATION and INQUEST

On 12 June 2025 I commenced an investigation into the death of Samuel Martin BROWN. The investigation concluded at the end of the inquest . The conclusion of the inquest was

3 Drug related death

1a Drug Intoxication

CIRCUMSTANCES OF THE DEATH

4 This case relates to the death of a2 29 year old male found deceased at Elliott Court, Rotherham on 30 March 2025. He had registered with a new GP practice approximately 6 weeks prior to his death. In evidence that practice recognised that there was a need for a medication review as Samuel was in receipt of a significant number of medications for pain which he may no longer require. The previous GPs appear to have continued to add medications to Samuel's primary care prescription list and he was therefore able to routinely access medications to which he was addicted.

His death was as a result of drug intoxication and a number of those drugs were ones which were prescribed by the GP. Samuel's family are concerned that his medication was not adequately monitored by general practice and his drug seeking behaviour, linked to his addiction, was not appropriately managed by primary care.

CORONER'S CONCERNS

5 During the course of the inquest the evidence revealed matters 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 as follows. –

As the commissioners for primary care services I am concerned that the prescribing regime in primary care did not identify potential addiction and drug seeking behaviour or review medications with a view to checking they are actually required.

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you the NHS South Yorkshire Integrated Care Board have the power to take such action.

YOUR RESPONSE

7 You are under a duty to respond to this report within 56 days of the date of this report, namely by 22nd January 2026. 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons, [redacted], RDaSH and Gateway Primary Care.

8 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.

4 December 2025

9 [redacted]

Assistant Coroner for South Yorkshire East