ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NHS England – [redacted] (Chair)** **2.** **3.** **4.** **5.** **6.** **7.** **8.** **9.** **10.**
1	**CORONER** I am Professor Paul Marks, Senior Coroner, for the Coroner Area of City of Kingston Upon Hull and the County of the East Riding of Yorkshire.
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 23rd July 2024, I commenced an investigation into the death of Amy Grace Pugh, aged 23 years. The investigation concluded at the end of the inquest on 26th November 2025, the narrative conclusion of the inquest was:- **Amy Grace Pugh took an overdose of [redacted] and other drugs around midnight on 10th April 2024 which resulted in her death on the morning of 11th April 2024. Whilst it is certain she took the drugs, it is not possible to discern her intent.**
4	**CIRCUMSTANCES OF THE DEATH** **Amy Grace Pugh had a complex psychiatric history comprising emotionally unstable personality disorder, post-traumatic stress disorder, attention deficit hyperactivity disorder, anxiety and depression as well as drug and substance misuse. She had a proclivity to self-harm [redacted] and taking overdoses of medication.**

	She received a custodial sentence of 18 months imprisonment which she served at HMP Low Newton and was released on 27th March 2024. Whilst in prison two Assessments, Care in Custody and Teamwork (ACCT) were opened and subsequently closed. The ACCT's were opened due to self-harming behaviour whilst in custody. On her release she was inadequately supported by various agencies and the combination of this lack of support resulted in the recurrence of self-harming behaviour and a serious deterioration in her mental health, which had been stable during the latter part of her incarceration. Two hospital attendances resulted from applying a ligature to her neck and later the same day, 3rd April 2024, from a combined overdose of medication and consumption of alcohol. She required elective ventilation in the intensive care unit of Scunthorpe Hospital until the effects of alcohol and drugs had passed off. On regaining consciousness on 5th April 2024, she displayed psychotic symptoms and was detained under 5(2) of The Mental Health Act 1983. Despite this, she absconded from hospital but was returned the same day. She underwent a mental health assessment on 8th April 2024 which resulted in her informal admission to Avondale Unit in Hull. She obtained leave on 10th April 2024 to visit her twin sister in York. Whilst in the company of her sister, she appropriated her sister's drugs which comprised pregabalin, diazepam, gabapentin, codeine and propranolol. She returned as scheduled to the Avondale Unit on 10th April and queries were raised around 21:00 hours that she might be intoxicated. She denied this. At 22:00 hours she collapsed in the garden of the facility and lost consciousness but recovered after about 2 minutes. **Paramedics were called and attended, by which time she was fully conscious with essentially normal vital signs.** **Out of an abundance of caution, paramedics advised that she should go to hospital to be checked, but Amy refused and the default position was that staff of the Avondale Unit would observe her overnight.** **Observations were conducted at 01:00 and 02:00 hours visually through a flap in the door of Amy's bedroom with neither entry into the room or physical examination being carried out. In all the circumstances, this was an inadequate means of assessing Amy.** **At 03:00 hours, a further observation occurred, this time with entry into Amy's room. She had no pulse, was not breathing and had fixed, dilated pupils. Despite cardiopulmonary resuscitation being carried out, there was no return of spontaneous circulation, and she was declared deceased at 04:13 hours at Hull Royal Infirmary.** **The aggregation of failings in this case may be considered to have more than minimally, negligibly and trivially resulted in Amy's death.**

5	**CORONER'S CONCERNS** 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. – Following Amy's admission to Avondale Unit on 8th April 2024, clinical staff were unable to access important records pertaining to Amy's mental health from partner NHS mental health institutions and this compromised her assessment and subsequent management. The approved findings of fact are attached.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation has the power to take such action. This may include, for example, ensuring that medical records systems within the NHS are compatible, can be accessed 24 hours per day by partner organisations and hence permit the data systems to "talk to each other."
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 9th March 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons Next of Kin, Humber NHS Mental Health Trust, Government Legal. I am also sending a copy to NHS England and equivalent organisations in the other countries of the United Kingdom. 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	[redacted] **12th January 2026**