



Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	<p>REGULATION 28 REPORT TO PREVENT DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1 Sundon Medical Centre 2 [REDACTED] Secretary of State for Health & Social Care</p>
1	<p>CORONER</p> <p>I am Emma WHITTING, Senior Coroner for the coroner area of Bedfordshire and Luton Coroner Service</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 28 October 2025 I commenced an investigation into the death of Paul Robert Joseph NASH aged 58. The investigation concluded at the end of the inquest on 12 March 2026. The conclusion of the inquest was: <i>The Deceased died following an epileptic seizure after running out of his epilepsy medication which meant he had missed three doses; although the reasons for him suffering a seizure at this time remained unclear.</i></p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>The Deceased suffered with epilepsy secondary to HSV encephalitis which he had developed in 2014 and had resulted in him sustaining a significant brain injury at this time. Since then his epilepsy had become well controlled with Carbamazepine and he had not suffered a seizure since 2016. From June 2025, he had been taking Carbamazepine at a dose of 500 mg twice daily. However, in September 2025, he did not appear to have requested all of his prescriptions for this and, although his full prescription was requested on 20 October 2025, on the morning of 21 October 2025 he had reported to HEADWAY in Luton that he had taken his last dose of his epilepsy medication. Although HEADWAY contacted his GP on his behalf and requested a prescription urgently, it was not ready for collection by the Deceased the following day. Having not been heard from after the evening of 22 October 2025, at around 09.30 hours on 23 October 2025, he was found deceased in his bed at his home. Paramedics confirmed his death at 09.41 hours and evidence at the scene suggested he had suffered a seizure during the night.</p>
5	<p>CORONER'S CONCERNS</p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows: (brief summary of matters of concern)</p> <p>For GP Surgery only:</p> <p>1. During the phone call with the Surgery on 21 October 2025, HEADWAY made it clear to</p>



	<p>the Surgery that the Deceased had run out of his Carbamazepine (seizure medication) completely and, although he had taken that morning's dose, if he did not receive more medication that day he would not have his evening dose or any other doses. Although HEADWAY was reassured that the GP would be notified that the Deceased had run out of his seizure medication, this fact did not appear to have been conveyed to the GP and the prescription was not prioritised to ensure he received it the same day.</p> <p>For Sec. of State DH&SC only:</p> <p>2. The Deceased's Consultant Neurologist indicated that many epilepsy patients across the country currently experience difficulties in obtaining sufficient quantities of medication to ensure optimum seizure control i.e. it is difficult for them to obtain batch quantities to ensure they always have access to some in the event that they find they are running low or there are delays in the pharmacy processing a repeat prescription (apparently in some areas processing can take up to 10 days).</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>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.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by May 14, 2026. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons</p> <p>Headway LUTON Bedfordshire Hospitals NHS Trust [REDACTED]</p> <p>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.</p> <p>I may also send a copy of your response to any person who I believe may find it useful or of interest.</p> <p>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.</p> <p>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.</p>
9	<p>Dated: 19/03/2026</p> <p>[REDACTED]</p> <p>Emma WHITTING Senior Coroner for Bedfordshire and Luton Coroner Service</p>