VERONICA HAMILTON-DEELEY DL,
LL.B.
Her Majesty's Senior Coroner
for the City of Brighton & Hove

THE CORONER'S OFFICE
WOODVALE, LEWES ROAD
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CORONERS SOCIETY OF ENGLAND AND WALES

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	THIS REPORT IS BEING SENT TO: **1. [redacted] Chief Executive South East Coast Ambulance Service** **2. [redacted] Medical Director** **3. [redacted] Associate Medical Director** **4. [redacted] Deputy Medical Director** **5. Cc [redacted]**
1	**CORONER** I am Veronica HAMILTON-DEELEY, Senior Coroner, for the City of Brighton and Hove
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 7th September 2021 I commenced an investigation into the death of **Lisa CODLING.** The investigation concluded at the end of the inquest on **29th January 2021**.The conclusion of the inquest was a Narrative Conclusion as follows: - **On the evening of the 5th September 2020 Lisa Codling took a deliberate, impulsive overdose of an extremely high dose of Paracetamol. From the evidence and on the balance of probabilities I FIND that she expected emergency services to arrive and help her- the conversation she had with ambulance services makes that clear. Unfortunately an ambulance did not arrive until 3 hours and 10 minutes after the initial call and 2 hours and 20 minutes after the last conversation with Lisa. By the time they arrived she was unconscious and had aspirated. Her temperature was 34.8 so she had been "down" for a not inconsiderable amount of time. I believe her conscious level dropped shortly after 20:30 hours. If ambulance services had arrived sooner there is a reasonable chance that Lisa could have received attention in ICU which might have changed the outcome.**

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4	**CIRCUMSTANCES OF THE DEATH** **Lisa Codling was a 49 year old lady with a long history of anxiety and depression. She had a troubled personal life and reacted badly to adverse life events. She was not coping with the activities of day to day living. On 5th September 2020 after an emotionally charged encounter she took an overdose of paracetamol. Her death was confirmed by paramedics at 23:00 hours.** See Record of Inquest
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: – (1) **In her email of 12th October 2020 [redacted] gave (in response to my question) her reply as to why South East Coast Ambulance Service would not be conducting a Serious Incident Report. The penultimate point stated "clinicians advise that paracetamol will not kill a patient within a 3 hour timeframe although a paracetamol overdose should still be considered a time sensitive emergency." In this case of acute overdose the ambulance service took 3 hours and 10 minutes to arrive. Too late for Ms. Codling.**
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND your organisation 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 **14th May 2021**. 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

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	Persons :- 1. [redacted] - Father 2. Dr [redacted] 3. [redacted] of Quality and Nursing Clinical Commissioning Group 4. Secretary of State for Health, Department of Health 5. [redacted] Chief Executive, NHS England 6. [redacted] – Chief Executive CQC. 7. Dr [redacted] Chief Executive Officer, Medicines & Healthcare Products Regulatory Agency 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	**Date: 19th February 2021 SIGNED BY:** V Hamilton Deeley **Senior Coroner Brighton and Hove**