REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Sandwell and West Birmingham Hospital Trust**
1	**CORONER** I am Mrs Joanne Lees, Area Coroner, for the coroner area of The Black Country Jurisdiction.
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 6/11/20 I commenced an investigation into the death of Sarah Brady dob 26/1/45. The investigation concluded at the end of the inquest on 5/5/21. The conclusion of the inquest was Suicide. The medical cause of death was recorded as 1a) Multiple Organ Failure, 1b) ██████ overdose 2) Stroke and Depression. The inquest found and recorded the following facts; On 4/8/20 the deceased, a 75-year-old lady was admitted to hospital having been found unresponsive following a presumed overdose of ██████. Ante mortem toxicology tests revealed significant concentrations of ██████ ██████. Despite treatment with antidotes and antibiotics, she continued to deteriorate and went into multi organ failure and sadly passed away in hospital on 8/8/20. Mrs Brady had a historical diagnosis of depression and PTSD and more recently functional neurological disorder with longstanding chronic back pain. She had a history of intentional medication overdose in March 2020 and had recently self-discharged from hospital 3 days before this admission. Mrs Brady was in possession of a significant amount of prescription medication at the time of her death and there was evidence of recent deterioration in her mental and physical health in the weeks leading up to her death.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Brady was a 75 year old lady admitted to City Hospital, Birmingham on the evening of 4/8/20 having been found unresponsive at home following a presumed overdose (██████). She had Multiple recent hospital admissions with back pain, abdominal pain, headache and photophobia and had Self-discharged from hospital on 01/08/2020 following an admission with back pain; underwent an MRI spine and was discharged with analgesia. A urine toxicology screen from was positive for ██████,

	. Blood Paracetamol levels were less than 10 mg/l and blood salicylate levels were less than 50 mg/l. Her blood ethanol level was < 100 mg/l (not detectable). She was treated with Naloxone and antibiotics for an aspiration pneumonia. Quantitative toxicology results from admission showed , and . All of these were consistent with the diagnosis of significant overdose. Given the response to extra doses of antidote the rate of the Naloxone and Flumazenil infusions were increased. Mrs Brady deteriorated into multi organ failure despite treatment and on the afternoon of 8/8/20 the Naloxone and Flumazenil infusions were discontinued at 12:57 hours and Mrs Brady passed away in hospital shortly afterwards.
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 could 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) Mrs Brady had a long history of Chronic pain, mental health problems and informal admissions in Psychiatric hospitals. She had a recent history of intentional medication overdose in March 2020 and erratic compliance with her medications. (2) Due to the above, Mrs Brady's GP was only issuing 7 day prescriptions due to her high risk of overdose in order to limit medication availability. This included amongst others. (3) Mrs Brady had already been issued with a prescription by her GP on 14/7/20 for her regular prescription medication; (4) The inquest heard evidence that following a hospital admission in early July 2020, Mrs Brady was medically fit for discharge on 15/7/20 and a prescription was issued by the Sandwell & West Birmingham Hospital Trust for 14 days of (4) It was unclear from the evidence whether the prescription had actually been fulfilled by the hospital. I am concerned that Mrs Brady was issued with a prescription in excess of 7 days and for medication that had already been prescribed to her by her GP only the previous day and against a background of overdose and erratic compliance with her medications; (5) The levels of found as a result of qualitative testing appeared to be well in in excess of her prescriptions and there was evidence that Mrs Brady may have been stockpiling medication. It is possible that the additional prescription, if supplied may have formed part of the medication taken by way of overdose. (6) I heard at inquest that another similar prescription issued on 28/7/20 following a further admission had NOT been fulfilled.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 2/7/21. 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 [redacted] (daughter of the deceased). 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. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	JMLees **5/5/21** **Joanne M. Lees Area Coroner**