	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted]** **2. Chief Coroner** **3. Family of Miss Meredith** **4. The Practice Manager, Browning Street Surgery** **5. General Medical Council** **6. Derek Winter, HM Senior Coroner, Sunderland**
1	**CORONER** I am Mrs Margaret Joy JONES Assistant coroner for the coroner area of Staffordshire South
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** On 5 September 2013 I commenced an investigation into the death of Pauline Meredith Age 42. The investigation has been heard. The deceased died from a self administered overdose of prescription drugs.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had been a patient at Browning Street Surgery Stafford since 1983. She had been seen weekly or fortnightly by [redacted] for over 15 years. She had a long history of anxiety, depression, alcohol dependency, binge drinking and periods of self harm with symptoms of paranoia, believing that neighbours were in her loft and that she was being talked about, followed and filmed at home. She complained of chronic headaches, knee and back pain and seizures due to alcohol withdrawal. Her long term medication included venlafaxine, lamotrigine, lorazepam, propranolol, zoplicone and pregabalin. She was reluctant to engage with alcohol services. Her medication was on a weekly prescription in order to prevent over-usage and misuse. In February 2013 she reported to her GP that she had doubled up on her lorazepam tablets and advice was given to her. She complained of abdominal pains around an incisional scar. She was already on maximal dose of her existing medication so morphine 10mg twice daily was added to her prescription. She reported improved pain control so that was continued. Between February and August she reported increased stress, continued pain and in July her GP recorded the words "physical and emotional mess" She was reluctant to engage with community mental health services but a referral was faxed to them by her GP on the 4th August 2013.She was found dead in her flat on the 30th August 2013 and on that day a letter arrived inviting her to contact the Community Mental Health Services. She had bolted and alarmed all doors and hidden knives around the flat. The cause of death was mixed drug toxicity. The level of morphine was in itself at a fatal level; the levels of tramadol and propranolol were excessive. There was an ethanol concentration of 49mg/dl at post mortem examination. There was no evidence that the deceased intended to take her own life, indeed she was described as upbeat by her family the evening before her death.

	The family evidence was that at the date of death there was a huge amount of prescription medication at her flat and that they had previously asked why she was being prescribed such large amounts of medication and that following the addition of morphine to her medication there was a worrying change in her behaviour. The family met with [redacted] to highlight the changes in her behaviour but they felt their concerns went unheeded morphine continued to be prescribed. It was acknowledged that GP's have no way of checking to ensure that patients are taking the prescribed medication correctly, but if they are not it does not take long to hoard quite a considerable amount. Miss Meredith had never requested additional prescriptions. [redacted] view was that morphine was not contra-indicated for this patient and that she was having break through pain with her existing medication. He acknowledged there was no formal process for medication review and no practice team meetings to discuss patients such as Miss Meredith but that a review of the circumstances is planned following this inquest.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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) The amount of medication prescribed to the deceased over many years with no formal medication review process. (2) The more recent addition of morphine to the prescription for a patient already on a high dose of pain killers and with alcohol dependence (3) The family's perceived reluctance by the GP to listen to the concerns expressed by them with regards to the changed behaviour of the patient following the addition of morphine. (4) The lack of any team meetings with colleagues affording an opportunity to discuss challenging patients with colleagues. (5) The lack of a more timely proactive approach with regards to involving community mental health services.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you, [redacted] and staff at your practice 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 7 March 2014. I, the assistant 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] [redacted] [redacted] [redacted] General Medical Council and The Practice Manager, Browning Street Surgery. 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	**10 January 2014** **Margaret J Jones** **HM Assistant Coroner** **Staffordshire South** _____