REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] **Practice Manager, Heaton Moor Medical Centre, 32 Heaton Moor Road, Stockport SK4 4NX.** 2. **R Simon Stevens, CEO NHS England, NHS England, PO Box 16738, Redditch B9 9PS** 3. [redacted] **Medical Director NHS England Greater Manchester, 3 Piccadilly Place, London Road, Manchester M1 3BN**
1	**CORONER** Andrew Bridgman, Assistant Coroner, for the coroner area of Manchester 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 and INQUEST** On 2nd November 2015 an investigation was commenced into the death of Fred Whittaker who died at his home address on 25th October 2015. The investigation concluded with an Inquest held on 8th July 2016. The conclusion of the Inquest was: **Narrative: Mr Whittaker died from the combined effects of a developing bronchopneumonia and the consumption of excessive amounts of codeine, methadone and alcohol.** Medical cause of death Ia Bronchopneumonia ; and combined Codeine, Methadone and Alcohol Toxicity II Cirrhosis of the Liver due to Alcoholism and Hepatitis C; Type 2 Diabetes Mellitus; Hypertensive Heart Disease
4	**CIRCUMSTANCES OF THE DEATH** Mr Whittaker was a 37 year old gentleman diagnosed with schizophrenia who was also known to abuse drugs, namely benzodiazepines, codeine and alcohol. In the early hours of the 24th October 2015 Mr Whittaker summoned an ambulance as he was having chest pains and feeling drowsy. He was taken to Accident and Emergency at Stepping Hill Hospital where he first admitted taking two codeine tablets with a large amount of alcohol. He later admitted to having taken four pots of methadone. Naloxone was administered by infusion and his GCS by 8.40am had returned to 15. At about 9.30am Mr Whittaker removed his cannula for the Naloxone infusion. At 11.01 am Mr Whittaker self-discharged and went home. He was seen by a support worker at about 12.30pm; he was noted to be well and did not appear to be under the influence of drugs or alcohol. He was given his prescribed medication for that day.

	On the morning of the 25th October 2015 Mr Whittaker was found dead in his bed at his flat.
5	**CORONER'S CONCERNS** An important issue in the Inquest was the continued prescription of Clonazepam by the Heaton Moor Medical Centre despite the written request on 17th August 2015, from Mr Whittaker's treating psychiatrist, [redacted] that this medication be stopped. The evidence given to me by [redacted] a partner at the Heaton Moor Medical Centre, suggests that although the prescription was stopped it was started again in error. [redacted] advised that, a) On receipt of [redacted] request the drug was moved from the Repeat Prescription list to the Past Prescription list, without any reference in the records of the reason as to why the Clonazepam was being stopped. b) On or about the 19th August 2015 the pharmacy which administered Mr Whittaker's medications requested a repeat prescription. c) It was likely that upon receiving that request Clonazepam was simply moved back on to the repeat prescription by one of the doctors at the Practice on being advised by an administrator of the Pharmacy's request. This is clearly an unacceptable error. I accept that, on this occasion, this error played no part in Mr Whittaker's demise but it is not difficult to imagine a completely different set of circumstances where such an error would give rise to a risk of death. [redacted] evidence was that there were no standard directions as to how to manage this as a situation and that other practices may adopt the same simple policy of transferring the drug from one list to another. 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. That Heaton Moor Medical Centre does not have a mechanism whereby the reasons or requests or decisions that a patient is no longer to be prescribed a particular drug are recorded in the clinical records. 2. That this poor practice may not be limited to Heaton Moor Medical Centre and is replicated in many GP practices in the Northwest and indeed, nationally.
	ACTION SHOULD BE TAKEN In my opinion action should be taken by Heaton Moor Medical Centre to develop a system such the risk of the inadvertent re-prescription of discontinued medications is reduced to its minimum or negated. In my opinion NHS England should draw to the attention of all GP practices this potential for the inadvertent re-prescription of discontinued medications and to take steps to

	ensure the risks are reduced to its minimum or negated.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 8th September 2016. 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. 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	**14th July 2016** **Andrew Bridgman** **Assistant Coroner**