REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Practice Manager of Delamere Medical Practice, Clinical Chair of Trafford Clinical Commissioning Group (CCG), Secretary of State for Health
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner area of South Manchester
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 10th August 2018 I commenced an investigation into the death of Jacqueline Marie Elliott. The investigation concluded on 4th January 2019 and the conclusion was one of accidental death. The medical cause of death was **1a) Combined drug toxicity (Tramadol, Amitriptyline and Pregabalin); II) Steatohepatitis**
4	Jacqueline Marie Elliott had a long-standing history of back pain and was on medication for this. On 9th August 2018 she was found deceased at her home address [redacted]. Post-mortem found that her liver function was reduced. In addition, toxicology found a combination of drugs causing significant drug toxicity. Her reduced liver function would have impacted her body's ability to metabolise the drugs ingested.
5	<u>CORONER'S CONCERNS</u> 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. – The inquest heard that: 1. The GP practice computer recording system showed drugs that were clearly on repeat prescription as drugs that were acute prescriptions. As a result the inquest was told that the medication reviews carried out would not pick up on and would not review those prescriptions. The medication reviewer would not therefore have a full overview of her prescribed long term medication; 2. The notes made by GPs and the ANP who had seen her/had telephone consultations lacked detail and so it was difficult to assess what information had been provided previously and what advice she had been given; 3. There was no detail provided in the notes at the inquest of the extent or issues considered during the medication reviews that were recorded as having taken place; 4. There was a recorded history of non-compliance and deliberate self-overmedication of painkillers by Mrs Elliott. Despite that a GP immediately before her death in a telephone consultation prescribed her with 100 tramadol tablets whilst recording that she needed an urgent review. The rationale for prescribing this volume of medication was unclear from the notes; 5. There was a lack of continuity of care. Mrs Elliott saw a variety of different locum GPs. This meant that no clinician had an overview of her and her health. As a result, painkillers were repeatedly prescribed and other potential ways of managing her persistent back pain were not explored. This led to a significant reliance by Mrs Elliott on painkillers to manage her on going back problems. The inquest was told that the lack of continuity of care was due to a national shortage of GPs and was a national not local issue.
6	ACTION SHOULD BE TAKEN In my opinion, action should be taken to prevent future deaths and I believe you 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 8th March 2019. 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 namely [redacted], Mrs Elliot's next of kin, who may find it useful or of interest. 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	**Alison Mutch OBE** **HM Senior Coroner** **11.01.2019**