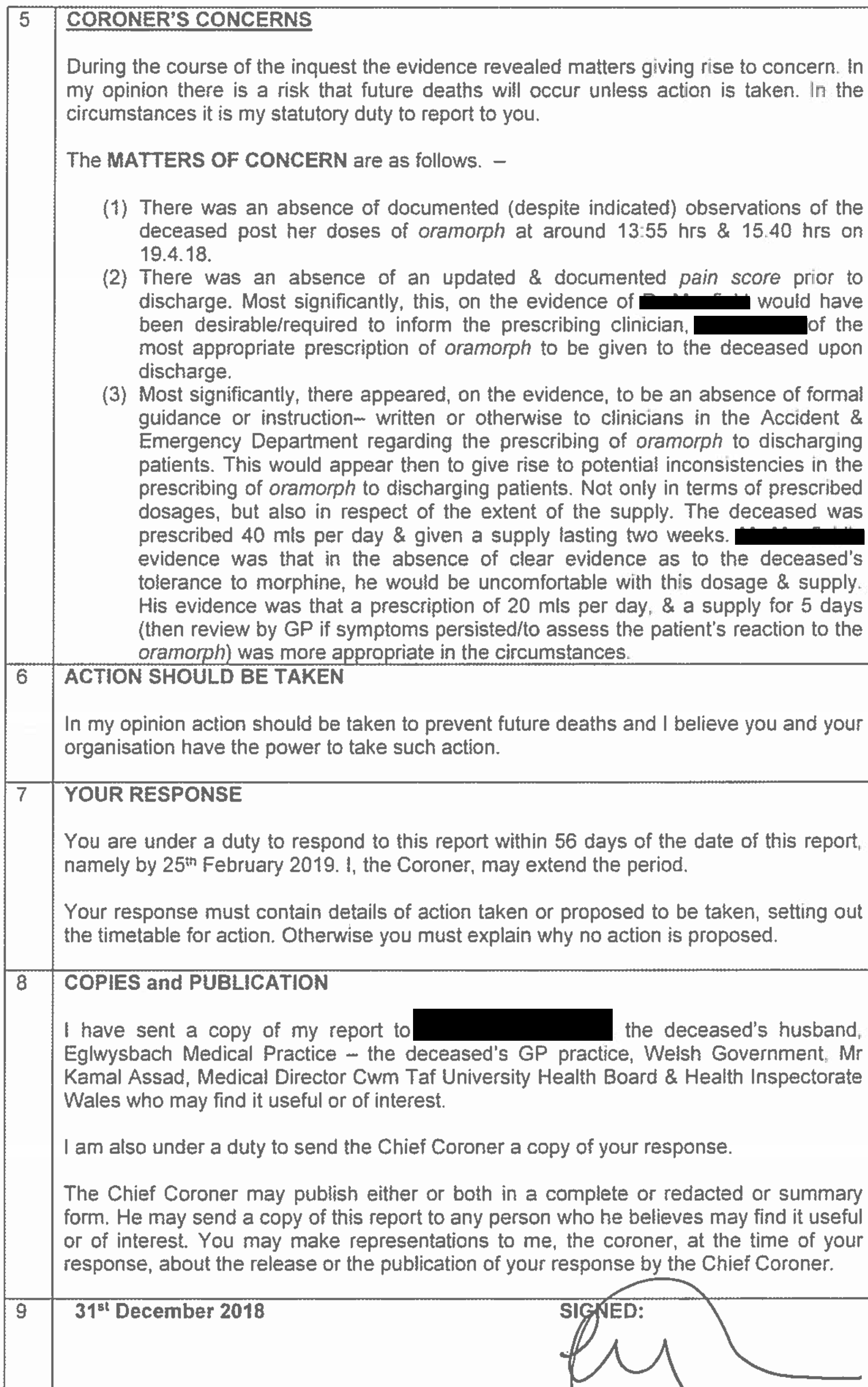
ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **The Chief Executive Cwm Taf University Health Board**
1	**CORONER** I am Graeme Hughes, Area Coroner, for the coroner area of South Wales Central
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** I commenced an investigation on the 31st October 2018 into the death of Janice Mary Davies. Investigation concluded at the end of the inquest on 14th December 2018. The conclusion was Drug Related (prescription) Accidental death and the medical cause of death was *1a. Morphine Toxicity and Bilateral Rib Fractures 1b. Mechanical Fall 2. Chronic Obstructive Pulmonary Disease and Chronic Kidney Disease*
4	**CIRCUMSTANCES OF THE DEATH** On 19.4.18 Janice Davies fell out of bed at home sustaining fractured ribs. She attended the Royal Glamorgan Hospital that day, given 2 x 5ml doses of *oramorph*, prescribed 4 x 10mls *oramorph* daily - a supply of around 2 weeks and then, discharged home. She was unable to tolerate the *oramorph* after around lunchtime on 20.4.18 and following medical advice from her GP, switched to her usual pain killing medication - co-codamol and *oxyNorm*. Sometime thereafter, the concentration of morphine in her blood reached a toxic level, likely contributed to by her undiagnosed chronic kidney disease (discovered at post mortem examination). This has likely caused respiratory depression, which, on the background of impaired lung function has led to her death at home at [redacted] in the early hours of 21.4.18. In *broad* terms, the Inquest focused upon:- a. The appropriateness of the care provided to the deceased at Royal Glamorgan Hospital on 19.4.18 & from her GP on 20.4.18 b. The dosages of *oramorph* given & prescribed to the deceased at Royal Glamorgan Hospital. c. The observations of the deceased on 19.4.18 d. The discharging of the deceased on 19.4.18 e. The content of the advice (by telephone) given by her GP on 20.4.18 regarding her toleration of *oramorph* f. The causal effects of the dosages of *oramorph* in the setting of the posthumously identified chronic kidney disease



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) There was an absence of documented (despite indicated) observations of the deceased post her doses of *oramorph* at around 13:55 hrs & 15.40 hrs on 19.4.18.

(2) There was an absence of an updated & documented *pain score* prior to discharge. Most significantly, this, on the evidence of [redacted] would have been desirable/required to inform the prescribing clinician, [redacted] of the most appropriate prescription of *oramorph* to be given to the deceased upon discharge.

(3) Most significantly, there appeared, on the evidence, to be an absence of formal guidance or instruction– written or otherwise to clinicians in the Accident & Emergency Department regarding the prescribing of *oramorph* to discharging patients. This would appear then to give rise to potential inconsistencies in the prescribing of *oramorph* to discharging patients. Not only in terms of prescribed dosages, but also in respect of the extent of the supply. The deceased was prescribed 40 mls per day & given a supply lasting two weeks. [redacted] evidence was that in the absence of clear evidence as to the deceased's tolerance to morphine, he would be uncomfortable with this dosage & supply. His evidence was that a prescription of 20 mls per day, & a supply for 5 days (then review by GP if symptoms persisted/to assess the patient's reaction to the *oramorph*) was more appropriate in the circumstances.

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 25th February 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 [redacted] the deceased's husband, Eglwysbach Medical Practice – the deceased's GP practice, Welsh Government, Mr Kamal Assad, Medical Director Cwm Taf University Health Board & Health Inspectorate Wales 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 **31st December 2018** **SIGNED:**