## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. HM Secretary of State For Health** |
| 1 | **CORONER**<br><br>I am JAMES EDWARD THOMPSON Assistant Coroner, for the coroner area of County Durham & Darlington |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 13th February 2020 I commenced an investigation into the death of Laura Eve PARSONS, 36. The investigation concluded at the end of the inquest on 1st September 2020. The conclusion of the inquest was a narrative which found the deceased Laura Eve Parsons died on 5th November 2019 after consuming an excessive quantity of morphine which was prescribed to her, it's toxicity ultimately causing her death.<br>The medical caused of death was;<br>1a - Morphine Toxicity,Bronchopneumonia<br>2 - Metastatic Adenocarcinoma Of Tubo-Ovarian Origin |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>On 5th November 2019 police became aware of concerns for the deceased and entry was forced to her home address where she was found dead. An empty 500ml bottle of liquid morphine was recovered from a waste bin inside the address. A subsequent post mortem & toxicological examination revealed fatal levels of morphine in the deceased at the time of her death. |

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| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>Ms Parsons was prescribed liquid morphine to treat 'break through' pain for cancer. It was first prescribed on 9th August 2019. Ms Parsons was admitted to hospital on 10th August 2019 with an accidental overdose of morphine. It appears 180mls were consumed in a 12 hour period. She recovered and was discharged from hospital. The remainder of the prescribed morphine was discarded.<br><br>On 31st October 2019 Ms Parsons requested a repeat prescription of liquid morphine from her GP surgery. This was authorised and a 500ml bottle of liquid morphine was dispensed to Ms Parsons. On 5th November 2019 Ms Parsons was found dead due to ingesting a fatal amount of morphine.<br><br>At inquest evidence was given that information such as recent overdose would be added to the 'Active Problems' section on a person's medical records and would be prominent when any clinician accessed that person's records.<br><br>It was explained at inquest that when a patient applies for a repeat prescription so far as the request is within the permitted timescale to issue a repeat of the prescribed item, then the prescription would be issued without any further scrutiny and the electronic systems would not take a prescriber to the patient's medical records and in particular the 'Active Problems' section. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe your organisation have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 1st November 2020. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons - Family of Ms Laura Eve Parsons & Queens Road Surgery, Consett, County Durham and the Care Quality Commission.<br><br>I have also sent a copy to the NHS North East Commissioning Group.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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. |

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| 9 | **3rd September 2020** | **James Edward THOMPSON** |