REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: 1) [redacted] Donneybrook Medical Centre, Clarendon Road, Hyde, Cheshire, SK14 2AH; 2) Rt. Hon. Sajid Javid MP, Secretary of State for Health and Social Care.

CORONER

I am Chris Morris, Area Coroner for Manchester South.

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.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 27th August 2021, Alison Mutch OBE, Senior Coroner, opened an inquest into the death of Amanda Hesketh who died on 28th January 2021 at Tameside General Hospital, Ashton-under-Lyne, at the age of 53 years. The investigation concluded with an inquest which I heard on 6th and 7th June 2022, and which concluded with a Narrative Conclusion to the effect that Mrs Hesketh died as a consequence of complications of her pain relief medication. There was no evidence to suggest Mrs Hesketh misused her medication or took it otherwise than in accordance with prescribing directions in the period leading to her death.

CIRCUMASTANCES OF THE DEATH

Mrs Hesketh had a complex health history which included breast cancer with lymph-node involvement, following treatment for which she was left with severe, chronic pain. In 2019, Mrs Hesketh developed a sacral sore following a hospital admission which compounded her pain further.

By this stage, Mrs Hesketh was prescribed a range of analgesic agents to try and relieve her pain in the form of fentanyl patches, fluoxetine, tramadol, amitriptyline, gabapentin, and diazepam. Individually, these medicines had been prescribed by specialists either from the Christie Hospital or from Tameside General Hospital pain clinic.

Mrs Hesketh obtained these medicines over a number of years via repeat prescription from her GP practice.

On 28th January 2021, Mrs Hesketh was brought to Tameside General Hospital by ambulance, reporting diarrhoea and vomiting of a few days' duration. The Middle Grade doctor who assessed Mrs Hesketh considered it likely that she was suffering from gastroenteritis and arranged for her to be admitted under the care of the medical team.

Whilst still in the Emergency Department, Mrs Hesketh was found unresponsive and could not be resuscitated.

Following a post mortem examination and toxicological tests [redacted], Consultant Pathologist, concluded that Mrs Hesketh died as a consequence of combined toxicity of fentanyl, fluoxetine, tramadol, amitriptyline, gabapentin and diazepam.

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. –

[redacted]

1. Notwithstanding the actions the practice has taken in response to Mrs Hesketh's death, it is a matter of concern the partnership has yet to undertake or commission a systematic review of all patients receiving repeat prescriptions of multiple analgesics and formulate individual plans for each such patient;

To the Secretary of State for Health and Social Care

2. The court heard evidence from a General Practitioner as to difficulties patients encounter in accessing services from specialist pain clinics with lengthy waiting lists often being experienced. It is a matter of concern that patients being prescribed multiple analgesics continue to receive such medicines on repeat prescription with often with little or no specialist input;

3. It is a matter of concern that GP practices who have a significant number of patients with complex analgesia regimes do not universally engage practice pharmacists to complement the knowledge of doctors and enhance the advice provided to patients.

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.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by **12th August 2022.** 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

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to Birchall Blackburn Law on behalf of Mrs Hesketh's family. I have also sent copies of my report to Weightmans LLP on behalf of Tameside and Glossop Integrated Care NHS Foundation Trust.

I have sent a copy of my report to the Care Quality Commission, Tameside Metropolitan Borough Council and NHS Tameside and Glossop CCG 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.

Dated: 17th June 2022

Signature: Chris Morris HM Area Coroner, Manchester South.