REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1) Secretary of State for Health and Social Care; 2) Greater Manchester Health and Social Care Partnership
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater 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 28th May 2020 I commenced an investigation into the death of Marjorie Walker. The inquest concluded on the 3rd March 2022 and the conclusion was one of: **Narrative: Died from a combination of natural causes contributed to by a toxic level of prescribed medication given in hospital and neglect**. The medical cause of death was: **1a) Combined effects of gabapentin, morphine, buprenorphine on a background of congestive cardiac failure, chronic renal failure, chronic obstructive pulmonary disease, bronchopneumonia, cerebrovascular disease and hyperkalaemia**
4	CIRCUMSTANCES OF THE DEATH Marjorie Walker had a significant number of co-morbidities. She was on pain relief in the community including Fentanyl and liquid Morphine (for breakthrough pain). She had reacted poorly to an increase in opioid based pain relief in the community. She was admitted to Tameside General Hospital with a significantly raised INR. Whilst an inpatient she was prescribed Gabapentin [redacted] On 18th May 2020 she was transferred to the Stamford Unit. Whilst on the unit she had a series of falls. The second fall necessitated her going to the Emergency Department at Tameside General Hospital. Tests there indicated she had an acute kidney injury in addition to chronic kidney disease. She returned to the Stamford Unit and then back on 22nd May 2020 to Tameside General Hospital due to a further raised INR. The Gabapentin continued

	to be given at the previous dosage because it was not recognised by any of the treating clinicians or the hospital pharmacy review that it needed to be reduced because of her reduced kidney function. The increased risk of toxicity was not recognised. On 22nd May 2020 at the Stamford Unit her Fentanyl patch was changed to a Buprenorphine patch. Her Morphine Sulphate oral prescription was not changed to reflect the amendment in the amount of opioid being delivered through the patch. That she was on too high a dose was not recognised by the clinicians on the Stamford Unit, the clinicians on her return to Tameside General Hospital or at the hospital pharmacy review at Tameside General Hospital. Her raised potassium level on 26th May 2020 was not acted on for reasons that were unclear. On 27th May 2020 she was found unresponsive in her bed at Tameside General Hospital. CPR was not given because a DNA CPR was in place. The DNA CPR had not been completed in accordance with the Trust's protocol. Post Mortem examination included toxicology. The toxicologist found that Gabapentin was present at an above therapeutic level and at a level that is encountered in fatalities. Morphine and Buprenorphine that she was prescribed were also found.
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. – 1. The inquest heard evidence that despite the consequences for a patient of a DNA CPR it had not been completed in accordance with protocols. The inquest heard evidence that the importance of well documented and correctly completed paperwork in relation to DNA CPR was important in all cases but particularly in relation to vulnerable members of the community such as Mrs Walker; 2. Mrs Walker had lived with significant chronic pain for many years. Evidence was heard that she would have benefited from an appointment with a pain clinic for specialist input and the risks around pain medication could have been reduced with specialist input. The inquest heard that there were significant delays in accessing specialist pain clinics due to demand and capacity issues across the NHS; 3. Mrs Walker was prescribed Gabapentin as part of helping her to manage her chronic pain. The evidence was that the use of pain medication such as Gabapentin carried risk particularly in relation to a patient with underlying kidney issues. The inquest was told that a lack of understanding and recognition of monitoring kidney function including clearance results by health professionals including pharmacists and doctors alongside prescribing created a risk of overdose particularly of vulnerable patients. The inquest was told that the risk would be reduced by greater ease of access to results, more robust checking and education.

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 10th 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.
8	COPIES and PUBLICATION I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely 1) [redacted] on behalf of the family; 2) Tameside General Hospital, 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**  **15.06.22**