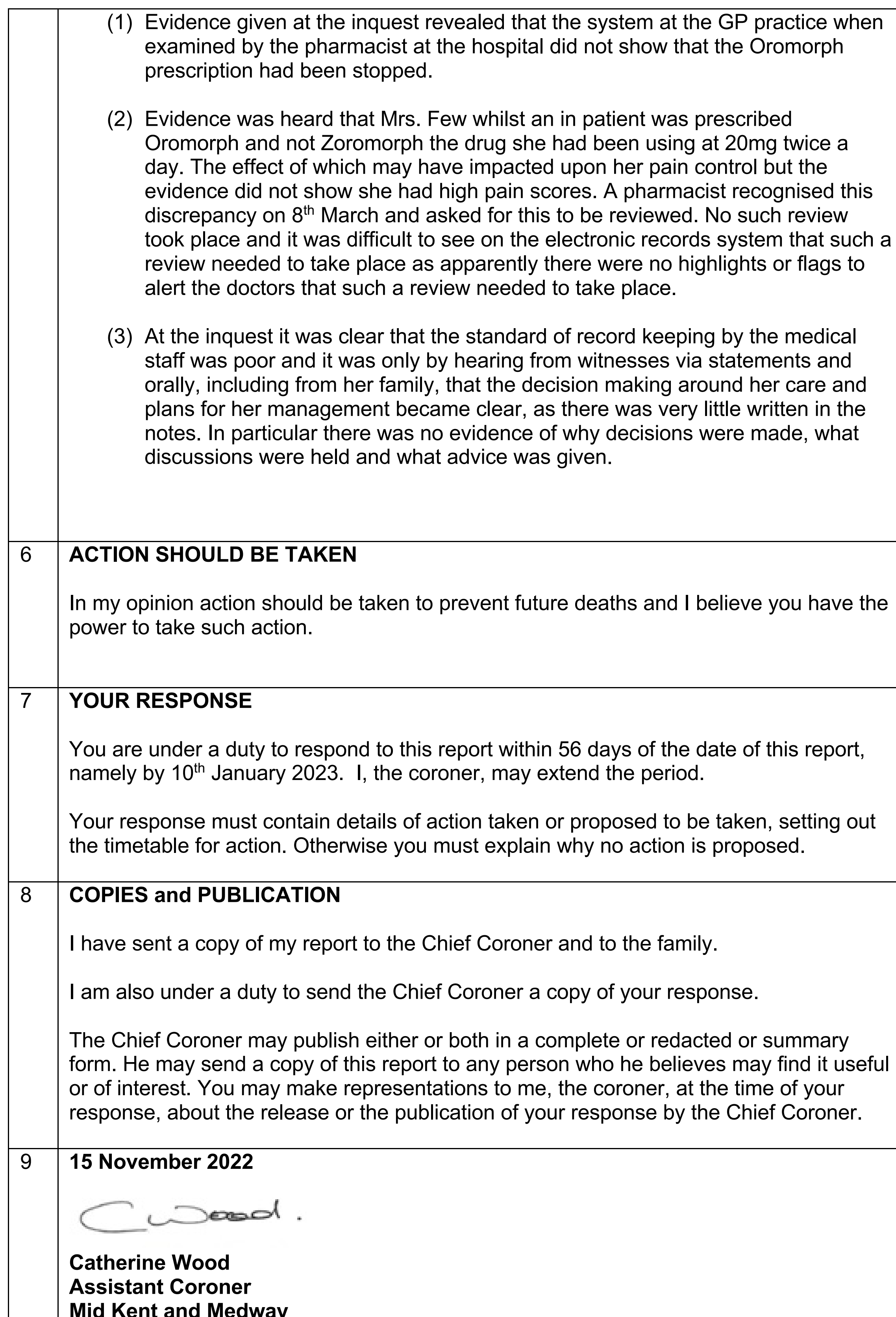
REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Medway NHS Foundation Trust**
1	**CORONER** I am Catherine Wood, assistant coroner, for the coroner area of Mid Kent and Medway.
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 the 5th July 2022 I opened an inquest into the death of Sally-Ann Few who died at home on 12th March 2022 as a consequence of Morphine toxicity. An inquest was heard today the 15th November 2022.
4	**CIRCUMSTANCES OF THE DEATH** (1) Sally-Ann Few had a past medical history of chronic obstructive pulmonary disease, entrocutaneous fistula, chronic gastric ulcer, pulmonary embolism, depression with a previous paracetamol overdose in 2020 and alcohol dependence. She had a prolonged hospital admission from July 2021 following a perforation of her gastric ulcer leading to months in hospital and necessitating intubation and a tracheostomy. She was discharged home and a medication review conducted by a community pharmacist on 15th December 2021 led to a decision to change her Oromorph to slow-release Zoromorph. A review by the same pharmacist led to discontinuation of the Oromorph and she was maintained on the slow-release prescription alone as her pain was under control. She was readmitted to hospital on 1st March 2022 with a deterioration in her breathing, shortness of breath and biphasic stridor which led to a diagnosis of cricoarythenoid fixation due to her period of prolonged intubation. She improved over the course of her stay and a plan was made for her to be discharged home with a referral to Guys and St Thomas's for further treatment. She was discharged home on 11th March 2022 with both slow-release morphine, Zoromorph, and the faster acting Oromorph which she had been prescribed during her stay in hospital. She was provided with 100mls of the latter and 2 weeks supply of the former. She was found dead at home on the morning of the 12th March 2022 and the bottle of morphine she had been discharged with was nearly empty. A post mortem revealed that she had died as a consequence of morphine toxicity.
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 could 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) Evidence given at the inquest revealed that the system at the GP practice when examined by the pharmacist at the hospital did not show that the Oromorph prescription had been stopped. (2) Evidence was heard that Mrs. Few whilst an in patient was prescribed Oromorph and not Zoromorph the drug she had been using at 20mg twice a day. The effect of which may have impacted upon her pain control but the evidence did not show she had high pain scores. A pharmacist recognised this discrepancy on 8th March and asked for this to be reviewed. No such review took place and it was difficult to see on the electronic records system that such a review needed to take place as apparently there were no highlights or flags to alert the doctors that such a review needed to take place. (3) At the inquest it was clear that the standard of record keeping by the medical staff was poor and it was only by hearing from witnesses via statements and orally, including from her family, that the decision making around her care and plans for her management became clear, as there was very little written in the notes. In particular there was no evidence of why decisions were made, what discussions were held and what advice was given.
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 January 2023. 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 family. 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	**15 November 2022** **Catherine Wood** **Assistant Coroner** **Mid Kent and Medway**