Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Hilltops Medical Centre, Kensington Drive, Great Holm, Milton Keynes** **2 [redacted] - NHS England National Director for Primary Care and Community Services** **3 [redacted] - Chief Medical Director, Bedfordshire, Luton and Milton Keynes Integrated Care Board**
1	**CORONER** I am Sean CUMMINGS, Assistant Coroner for the coroner area of Milton Keynes
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 04 July 2022 I commenced an investigation into the death of Jacqueline Sharman CAMPBELL aged 56. The investigation concluded at the end of the inquest on 08 February 2023. The conclusion of the inquest was that: Ms Jacqueline Sharman Campbell died on the 30th June 2022 at her home address. She had battled chronic backpain for more than 20 years. It was difficult to manage. She was prescribed large doses of gabapentin, tramadol and amitriptyline. She was also prescribed fentanyl patches and oral diazepam. She likely inadvertently overdosed on tramadol and that, in combination with the other medicines, all possessing the ability to depress the central nervous system, had the synergistic effect of causing respiratory depression and death.
4	**CIRCUMSTANCES OF THE DEATH** Ms. Campbell was medically retired. She worked for Transport for London and had an accident over 20 years ago where she injured her back. This resulted in continuing chronic back pain for which she took prescribed medication. Family report that she was not very good at managing this medication. During the late evening of Wednesday the 29th of June 2022 Jace Campbell, the son of Jacqueline came home and found his mother collapsed in her ensuite bathroom. Other family members have been contacted and came to Jace's assistance. Paramedics were called but they were unable to save Jacqueline and they confirmed her death on the 30th of June 2022.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) Ms Campbell had experienced a work-place related accident approximately 20 years prior to her death when she had fallen off a broken chair at work. She suffered with back pain, which became chronic, thereafter. She had a number of interventions including referral and attendance at pain clinics, manual therapy, CBT and pharmaceuticals. During her time with pain no clear cause was identified on MRI and other imaging. She was treated for chronic low back pain of indeterminate cause. Over the years she was treated with multiple, and escalating doses of, medications. These included at the time of her death, diazepam [redacted], amitriptyline [redacted], tramadol [redacted], gabapentin [redacted] and fentanyl patches [redacted] to be applied every 72 hours. She was found collapsed at home in her bathroom and there was a possibility of a positional component to the respiratory depression consequent on the long-lie. The medical cause of death was given by the pathologist [redacted] as 1a Central Respiratory Depression 1b Tramadol excess with fentanyl II Long lie following a fall, chronic post traumatic back injury. The police and paramedics attending the scene describe the finding of "hundreds" of packets of medications, some opened, some unopened. This polypharmacy was identified by the pathologist who conducted the post mortem (taking from the toxicology report) as "In summary, excess Tramadol ([redacted]) and a metabolite ([redacted]) are indicative of recent moderately excessive ingestion prior to death. Although lower than levels typically seen in fatalities, the moderate excess in conjunction with other prescribed drugs, most notably fentanyl are sufficient to have produced central respiratory depression. No other significant post mortem findings were noted, and the prolonged lie following a fall may well have contributed a postural component to the respiratory depression" Her GP, [redacted], gave clear and candid evidence. I accept the management of patients who describe intractable debilitating pain is challenging and difficult and that requests for other or increasing doses of medication can be difficult to resist. [redacted] agreed that the prescribing of the various drugs identified had potential to be dangerous. He told me that after a certain point the benefits of increasing or adding doses or medications in terms of pain relief were minimal. This scenario seems to be an invidious one for GP's and patients alike. [redacted] told me that subsequent to Ms Campbell's death the practice had convened and discussed the circumstances and agreed on regular reviews for patients taking these sorts of medication. There were no plans identified to actively look for these patients and to work to rationalize and / or reduce their medications. I am of the view that polypharmacy including gabapentinoids and opiates represents a severe safety risk in patients with a iatrogenic drug dependency. I consider that the risk in individuals like Ms Campbell of an inadvertent overdose of medications which have a cumulative and synergistic effect to depress the central nervous system can easily become extreme and lead to death. There have been a number of deaths in the Milton Keynes, Bedfordshire and Luton areas related to concomitant use of high dose and combination gabapentinoids and opioids.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 April 19, 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 following Interested Persons [redacted] I have also sent it to who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 22/02/2023** **Sean CUMMINGS** **Assistant Coroner for** **Milton Keynes**