Sarah Olga Riley, Assistant Coroner for North West Wales

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive of Betsi Cadwaladr University Health Board,** [redacted]
1	**CORONER** I am Sarah Riley, Assistant Coroner for North West Wales
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 8th December 2021, I commenced an investigation into the death of Ms Teresa Ann Bennett. The investigation concluded at the end of the inquest on the 9th February 2024.
4	**CIRCUMSTANCES OF THE DEATH** Teresa Ann Bennett was a female, aged 57 at the time of her death. She had a number of significant comorbidities, and her case was unusual and complex. Mrs Bennett was prescribed and taking 13 separate medications at the time of her death, seven of which, including Fentanyl, had side effects linked to the central nervous system. On the evening of the 30th November 2021, Ms Bennett's son had seen her taking her medication as usual. Ms Bennett retired to bed around 30 minutes or so later. Around 3am on the 1st December 2021, Ms Bennett's son found her asleep on the bedroom floor, appearing to have fallen from the bed. He helped her back to bed, ensuring she was comfortable, and left the room. At around 12pm on the 1st December 2021, Ms Bennett's son noticed that she was still in bed and it became apparent that she had passed away. Ms Bennett's son called the Emergency Services who attended and declared life extinct at 13.12pm. A post mortem examination was ordered and the cause of death recorded at inquest was: 1a Multi organ failure 1b Fatty liver and combined drug toxicity Mrs Bennett was prescribed [redacted] micrograms of Fentanyl over 72 hours. This was provided as one [redacted] patch and one [redacted] patch, both to be used at same time and identifiable as being different in size. At post mortem, [redacted] Matrifen (a form of fentanyl) patches were found on Ms Bennett's legs, two on the left and one on the right. This would amount to a dose of

	[redacted]. This dose differs from what was prescribed and issued by the GP and correlates to a significant dose increase of [redacted] over 72 hours, which is the equivalent of [redacted] of morphine daily. The toxicological analysis showed multiple drugs with Fentanyl being within the toxic and fatal range. It was recognised that Ms Bennett was prescribed a high dose of Fentanyl. Ms Bennett had been on a dose of [redacted]/ hr over 72 hours since 2008. The instructions recorded in the GP notes simply stated 'remove old patch and apply new patch every 72 hours' There was no evidence to suggest that Ms Bennett was not compliant with her medications. There was no evidence of ordering discrepancies, no stockpiling or using the medication incorrectly and there was nothing to indicate that Ms Bennett raised any concerns or mentioned any difficulties with the medication she was taking. The prescription dose of Fentanyl had not changed since 2008 and the directions for use had not changed. There was no evidence that the application of Fentanyl patches resulting in a dose of [redacted]micrograms was intentional. I found that Ms Bennett had inadvertently overdosed on Fentanyl, and that, in combination with other medicines, a number of which possessed the ability to depress the nervous system, led to her death. Ms Benett's GP practice was managed directly by the Health Board. It is Standard Health Board practice for medication reviews to be completed at 12-15 month intervals but, in Ms Bennett's case, that target had not been met on a single occasion since 2015. There is a lack of monitoring and no standardised process for medication reviews in the Health Board managed practices. There is a risk of harm if medication reviews are not undertaken at regular intervals, including a risk of death in complex cases, like Ms Bennett's. There is also a risk of harm or death if all pertinent matters are not considered during the reviews. At inquest, the Health Board produced an improvement plan that, inter alia, included actions to address the lack of compliance with the 12-15 monthly medication reviews. The target completion date for addressing the lack of compliance with the 12-15 monthly medication reviews is the 31st May 2025, a further 15 months from now. This, in my view, is not quick enough and I am concerned that future deaths may occur.
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 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) Lack of compliance with the target of 12-15 monthly medication reviews in Health Board managed GP practices. (2) No standard practice for medication reviews leading to a lack assurance that all pertinent matters will be covered and the approach varying between clinicians and practices. (3) The risk of inadvertent overdose in individuals like Ms Bennett, where medication that can cause e.g drowsiness and fatigue, is prescribed alongside strong opiates and other drugs that have the ability to depress the central nervous system when such medicines are prescribed without regular reviews nor specific advice in respect of the associated risks issued to patients e.g in Ms Bennett's case, she was instructed to simply "remove old patch and apply new patch every 72 hours"

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 10th April 2024. 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 Ms Bennett's son, as an Interested Person 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. 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 14th February 2024  Signature_____ Assistant Coroner for North West Wales