REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

IN THE MATTER OF THE INQUEST

TOUCHING THE DEATH OF LOUISE HELEN JONES

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Petroc GP Group Practice,** **St Columb** **Cornwall**
1	**CORONER** **I am Guy Davies, His Majesty's Assistant Coroner for Cornwall & the Isles of Scilly.**
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 21 November 2023 I commenced an investigation into the death of Louise Helen Jones. The investigation concluded at the end of the inquest on 11 June 2024. The medical cause of death was found as follows: *1a Respiratory Depression and Opiate Drug Use* *II Obesity* The four questions - who, when, where and how – were answered as follows: *Louise Helen JONES died on 1 October 2023 at no2 Mosquito Crescent St. Eval Wadebridge Cornwall following an unintentional overdose of morphine and bromazolam, and therapeutic use of codeine, diazepam, zopiclone and quetiapine. In combination, all of the aforementioned central nervous system depressant drugs are likely to have enhanced the overall effects on cardio-respiratory function which resulted in fatal respiratory depression.* The conclusion of the inquest was *Drug Related Death*.

4	**CIRCUMSTANCES OF THE DEATH** **At approximately 15.50 hours on 1 October 2023 Louise was found deceased in her home, kneeling on the kitchen floor with her head on the floor.** **Louise was 40 years old at the date of her death.** **Louise had suffered a complex medical history of physical and mental health conditions including anxiety and depression, and chronic pain due to fibromyalgia and back problems. For these conditions Louise was prescribed a variety of CNS depressant drugs including codeine, diazepam, zopiclone and quetiapine.** **In February 2023 Louise was admitted to Royal Cornwall Hospital with leg swelling and non-malignant leg pain. Investigations did not reveal a cause. Louise was prescribed oramorph by the hospital. At Louise's request this prescription was continued by Petroc GP Practice together with other CNS depressant drugs referred to above.** **The family view was that Louise had become addicted to morphine. The GP had raised the issue of addiction with Louise. Significant weight was attached by the GP to Louise's assurance that she was not addicted to morphine.** **The court found that there had been no attempt (or exit strategy formulated) to try and incrementally reduce and remove Louise's prescription of opiate-based drugs, or to adjust the co-prescription of opioids and benzodiazepines. At the time of Louise's death, the intention was for those prescriptions to continue.** **The court noted guidance referred to by NICE in connection with using opioid drugs for non-malignant pain:** ***Long term use of opioids in non-malignant pain (longer than 3 months) carries an increased risk of dependence and addiction, even at therapeutic doses….*** ***MHRA/CHM advice: Opioids: risk of dependence and addiction (September 2020) New safety recommendations have been issued following a review of the risks of dependence and addiction associated with prolonged use (longer than 3 months) of opioids for non-malignant pain.*** ***Healthcare professionals are advised to:*** • ***discuss with patients that prolonged use of opioids, even at therapeutic doses, may lead to dependence and addiction;*** • ***agree a treatment strategy and plan for end of treatment with the patient before starting opioids;*** **The court noted guidance referred to by NICE in connection with co-prescription of morphine and drugs such as diazepam, zopiclone and quetiapine.** ***MHRA/CHM advice: Benzodiazepines and opioids: reminder of risk of potentially fatal respiratory depression (March 2020)*** ***The MHRA reminds healthcare professionals that opioids co-prescribed with benzodiazepines and benzodiazepine-like drugs can produce additive CNS depressant effects, thereby increasing the risk of sedation, respiratory depression, coma, and death. Healthcare professionals are advised to only co-prescribe if there is no alternative and, if necessary, the lowest possible doses should be given for the shortest duration.***

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) There was no agreement with Louise before starting opioids, regarding a treatment strategy and plan for end of treatment as recommended by NICE. There was no practice policy requiring such an agreement. (2) There was no policy in place at the GP practice regarding long term (longer than 3 months) prescription of opioids. (3) There were no warning flags in place at the practice at the 3-month stage of morphine prescription, to reflect the MHRA/CHM advice referred to in NICE guidance, regarding the increased risk of addiction beyond this period. (4) There was no policy in place at the GP practice regarding co-prescription of opioids and benzodiazepines, to reflect the MHRA/CHM advice referred to in NICE guidance regarding the increased risk of respiratory depression and death.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 8 August 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 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	**12 June 2024** **Guy Davies**