REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Brinnington Surgery, Brinnington Road, Stockport SK5 8BS
1	**CORONER** I am Anna Morris KC, Assistant 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 Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 14th August 2024, I commenced an investigation into the death of Mr. Kumaran Chetty. At the inquest into his death on the 11th November 2024 I found that he **died from an acute cardiac episode, contributed to by fentanyl and morphine toxicity.**
4	**CIRCUMSTANCES OF THE DEATH** My findings at the inquest were as follows – The deceased was 51 years old at the time of his death. He had a number of chronic health conditions including ischaemic heart disease and cardiomyopathy. On the 19th April 2024 an ECG indicated that his left ventricular function was less than 25% ejection. He also suffered from chronic pain as a result of long standing colorectal issues and was under the care of a consultant. He was prescribed fentanyl by his GP in the dose of 1 25mg patch per 72 hours. He was also prescribed morphine sulphate. On the morning of the 9th May 2024, the deceased was found unresponsive in the kitchen at his home address. Paramedics attended and pronounced life to be extinct. Autopsy confirmed the presence of an acute left ventricular failure. Examination revealed the presence of 4 fentanyl patches on the upper back of the deceased, which was in

	excess of the amount he was prescribed. Toxicology reported the presence of fentanyl and morphine in levels associated with fatalities. There is no evidence that the deceased intended to take his own life. It is not clear whether his application of the patches was a mistake or a response to the level of pain he was experiencing. However, I find the excessive, even if accidental use of these strong opiates would have had a consequent effect on his already failing heart and is likely to contributed to his death from acute left ventricular failure.
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. – I heard evidence during the inquest from [redacted] of the practice. [redacted]'s evidence was that Mr. Chetty was being prescribed fentanyl patches through the practice for chronic pain. The evidence was that Mr. Chetty managed his own medication at home and was assessed to have capacity to do so. His last prescription was for 10 patches as 1 x 25mg patch per 72 hours. [redacted]s evidence was that this prescription should last Mr Chetty a month and was the maximum amount of this controlled drug that a patient could be prescribed at any one time. On the 17th April 2024 Mr. Chetty was seen by his Consultant at Salford Royal Hospital. A letter sent to Brinnington Surgery by [redacted] reported that Mr. Chetty had disclosed using multiple fentanyl patches in order to address his current levels of pain. This report of excessive fentanyl use outside of the prescribed regime was not identified by the Surgery upon receipt of the letter and did not trigger a medication review for Mr Chetty. I am concerned that the correspondence triage did not identify this excessive use of a controlled drug which is known to cause fatalities if abused. I am further concerned that there are no specific policies or procedures within the Surgery to flag up or review concerns around fentanyl abuse. As a known recipient of this and other strong opiate medication, all correspondence received by the surgery relating to Mr. Chetty's treatment and care had the potential to reveal important information about his ability to self-manage his medication.

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 9th January 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 following Interested Persons namely Northen Care Alliance NHS Foundation Trust and [redacted] on behalf of the family, 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 from. 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.
	Signed:  **Anna Morris** **HM Assistant Coroner**
	Dated: **14th November 2024**