Flixton Road
Medical Centre

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Private & Confidential
Ms Alison Mutch
HM Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

28 May 2025

Dear Ms Mutch,

Response to Regulation 28 Report into the death of Louise Danielle Rosendale

Thank you for your letter and for sharing with us the findings from the recent inquest, along with the matters of concern outlined in the Regulation 28 Report.

We would like to begin by expressing our sincere condolences to the family and loved ones of Ms Rosendale. We recognise that this has been an extremely difficult and distressing time, and we are deeply sorry for their loss. As a practice, we fully acknowledge the emotional impact that events such as these can have on those affected.

We welcome the opportunity to reflect on the circumstances of this case and to respond constructively. We have carefully considered the issues raised in the Prevention of Future Deaths report, particularly those relating to the prescribing and administration of opiates.

As part of our commitment to learning and improvement, we have undertaken a review of our current practices and will provide additional education and guidance to our staff to reinforce safe prescribing, monitoring, and administration of these medications. We are making changes which are relevant to addressing the concerns.

Background

1. **Regulation 28 Report into the death of Louise Danielle Rosendale**

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Our Response
To each of the matters of concern are provided as follows: -

Concern - Prescribed Opiates

The inquest heard that Ms Louise Rosendale had been prescribed opiates for many years despite the risks associated with long term opiate prescribing. The evidence before the inquest was that there had been very limited attempts to review the long-term prescribing of opiates to her.

Response to Concern

Ms Rosendale (our patient) had passed away, the review by the coroner noted that there was historic high use of opioids. Ms Rosendale was taking 120mg of Morphine via tablet form and taking oramorph also. Ms Rosendale had been taking historically high doses of opioids before becoming a patient at Flixton Road Medical Centre, due to symptoms of severe abdominal pain and had seen general surgeons and gastroenterologist who confirmed the high dose opioid use to control Ms Rosendale's pain.

Ms Rosendale was taking 120mg of oral morphine through tablets and liquid morphine when required. Ms Rosendale's patient history stated there were several admissions to casualty with severe pain.

Ms Rosendale transferred to Flixton Road Medical Centre in December 2019 following the closure of her previous GP practice, along with the doctors who had been caring for her. She continued to be seen regularly for general health reviews throughout 2020. In May 2021, she had a medication review with her regular GP, which included management of her mental health condition and medications prescribed by the mental health team.

Ms Rosendale was reviewed in the gastroenterology clinic in March 2022, where a continued diagnosis of pancreatitis was made. Despite ongoing severe pain, no changes were made to her opioid medication. At this time, she was also under haematology for chronic anaemia and cardiology for arrhythmias; all involved specialists were aware of her medications and raised no concerns.

In June 2022, a GP medication review confirmed the continuation of high-dose opioid treatment as per gastroenterology advice. Ms Rosendale reported that only by taking oral morphine sulfate (120mg daily) and Oramorph as needed, did she gain some relief. The risks of high-dose opioid use were discussed.

In September 2022, the Primary Care Network pharmacist switched her medication to Zomorph. A follow-up review in October 2022 resulted in no further changes. That same month, she attended Wythenshawe Hospital with severe abdominal pain. A CT scan showed no acute changes, and she was treated with additional opioids. A referral to gastroenterology was made.

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In March 2023, the medicines management team reviewed her prescription after she reported a lost bottle of Oramorph, later confirmed to have been mistakenly discarded by her father.
She was seen in August 2023 for ENT concerns and diagnosed with a deviated septum. Blood tests showed no abnormalities. In September 2023, she attended her annual health check with the nurse.

In November 2023, Ms Rosendale sustained a fractured clavicle after a fall and received treatment. She was reviewed by a GP in March 2024 for concerns about low B12, and blood tests were ordered.

In July 2024, the practice pharmacist conducted a medication review. Ms Rosendale later reported misplacing some Zomorph; the amount was calculated and replaced. A follow-up consultation reinforced the importance of adhering to the prescribed dose. Ms Rosendale stated her father assisted with her medication. She was advised not to take additional opioids beyond the prescription.

She was offered a face-to-face appointment on 18 September 2024, but did not respond. On 20 September, she contacted the surgery regarding ankle swelling and was seen the same day.

Flixton Road Medical Practice was notified of Ms Rosendale's death on the 25th of September 24. The cause of death was respiratory infection, but the pathologist noted the high levels of opioids in the patient postmortem results. There was also codeine which was not prescribed by the practice and the combination of both medications added to the respiratory depression.

As part of the practice's commitment to continuous learning and patient safety, a comprehensive review of opioid prescribing was undertaken. This included a revision of the opioid prescribing policy in line with current clinical guidelines, alongside the introduction of mandatory training for all prescribers to support safer opioid use. An audit of high-risk prescribing was completed to identify areas for improvement and ensure appropriate monitoring. Electronic safety alerts within the prescribing system were optimised to support clinical decision-making at the point of care. Structured medication reviews were reinforced as a routine part of ongoing care, particularly for patients on long-term or high-dose opioids. In addition, a standardised communication protocol was developed to ensure consistent, clear, and timely documentation and coordination between clinical teams involved in patient care. These actions aim to strengthen prescribing safety, enhance patient outcomes, and support a culture of continuous quality improvement.

To ensure that the learning from this case is fully embedded across our practice, we have developed an action plan to address the concerns raised, which is enclosed with this response. Key elements of our learning dissemination include publication on our internal learning platform (TeamNet), briefing sessions with the clinical team, and structured reflection during team meetings.

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On reflection, several areas have been identified where care could have been improved. Earlier identification of risks associated with long-term high-dose opioid use may have prompted more timely interventions. Greater patient involvement in decision-making could have supported shared understanding and safer management plans. There was limited external input from specialist services in reviewing ongoing opioid prescribing, and an absence of a formal monitoring framework meant that risk mitigation strategies were not consistently applied. Resource constraints also impacted the ability to implement more proactive, structured reviews. Opportunities were missed for more proactive monitoring of opioid use, supported by a clear and structured communication protocol across the clinical team. Additionally, ongoing training in opioid safety and polypharmacy was not embedded consistently across the team. Structured medication reviews should have been undertaken more frequently and in a multidisciplinary context. These findings have guided recent improvements aimed at enhancing clinical practice and ensuring safer patient care.

A more robust process for prescribing high-dose opioids has now been introduced to ensure greater clinical oversight and patient safety. This includes a clear prescribing protocol that outlines thresholds for escalation, mandatory documentation of clinical rationale, and multidisciplinary involvement in decision-making. All high-dose opioid prescriptions are now subject to regular structured medication reviews, with clearly defined intervals and oversight by both GPs and clinical pharmacists. Electronic prescribing systems have been updated to include enhanced safety alerts, specifically highlighting high opioid use, with a safety message now embedded in our EMIS clinical system to prompt prescribers at key decision points.

Additionally, any new initiation or dose escalation of high-level opioids requires a documented risk-benefit discussion with the patient, including exploration of alternative pain management strategies. This process is supported by ongoing staff training in opioid safety and polypharmacy and monitored through regular audits to ensure compliance and continuous improvement.

We have included the following documents for your consideration with our response.

1. **Investigation Action Plan**
2. **Regulation 28 – Response Final**
3. **Review of Opioids Treatment for non-Palliative Patients**
4. **Teamnet Page Opioids and Pain Management**
5. **Opioids Prescribing Protocol**
6. **SEA**
7. **Audit**

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In addition, we will share the key findings and learning points with our Primary Care Network (PCN) colleagues and across other practices within the Trafford area to support wider system learning and reinforce safe practice in the prescribing and management of opiates.

To ensure the effectiveness of the actions taken and to support continuous improvement, we will implement follow-up audits to monitor compliance with revised protocols and safety measures related to opiate prescribing. The audit results and learning will be reviewed at our practice meeting, where we will strive to ensure all new processes are acknowledged and embedded by all the clinical team.

Thank you once again for providing the practice with the copy of the regulation 28 report for our attention and remedial action.

Yours sincerely,

[redacted]

[redacted]
Partner
Flixton Road Medical Centre