

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Chief Executive Officer of Princess Alexandra Hospital 2. NHS England
1	CORONER I am Sonia Hayes, Area Coroner, for the coroner area of Essex
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 18 June 2024 an investigation was commenced into the death of Paolino AMICO, aged 63 years. The investigation concluded at the inquest on 3 November 2025. The conclusion of the inquest was a Narrative: Mr Amico's death from Metastatic Bladder Cancer was hastened and contributed to by multiple morphine overdoses between 10 and 11 June 2024 due to a prescription error that was not scutnised. Morphine reversal and subsequent pain relief was not managed according to the guidelines and Mr Amico suffered acute withdrawal syndrome. Medical cause of death of '1a Type 2 Respiratory Failure 1b Community Acquired Pneumonia, Inadvertent Morphine Overdoses and acute withdrawal syndrome 1c Metastatic Bladder Cancer with Advanced Clinical Frailty
4	CIRCUMSTANCES OF THE DEATH Paolino Amico had a history of metastatic bladder cancer that had not responded to treatment on a clinical trial. Mr Amico was discharged from hospital on 29 May 2024 and was oxygen dependent. Mr Amico developed severe bilateral pneumonia and was admitted into Princess Alexandra Hospital on 9 June 2024 and treated with antibiotics , nebulisers and fluids. Mr Amico was not seen in person by a doctor who altered his prescription in the

	emergency department on 10 June. On the afternoon of 10 June Mr Amico's medication chart was not scrutinised when he had a medical review as he was deteriorating. Due to a prescription error Mr Amico received multiple overdoses of a controlled drug morphine sulphate (slow release) on 10 and 11 June 2024 resulting in morphine accumulation that was partially reversed with naloxone on 11 June. Mr Amico was not deemed suitable for admission to intensive care for Naloxone infusion. Mr Amico died on 12 June 2024 at Princess Alexandra Hospital as a consequence of Type 2 Respiratory Failure due to Community Acquired Pneumonia and Inadvertent Morphine Overdoses with Metastatic Bladder Cancer with Advanced Clinical Frailty. There was a delay in raising a medical emergency when Mr Amico had elevated NEWS score of 10 and his morphine reversal and pain relief was not managed according to the guidelines and he suffered acute withdrawal syndrome.
5	<u>CORONER'S CONCERNS</u> 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) The consultant required a discharge plan for oxygen therapy to be in place before Mr Amico could go home. The hospital discharge plan and medications were confusing and the referral for oxygen therapy requirement was unclear, and the PAT testing for the machine was out of date. Paramedics advised the family that the oxygen provided on Mr Amico's discharge was low flow and was not meeting his oxygen requirements with his oxygen saturations at 68% and this immediately improved on ambulance crew equipment. (2) Mr Amico did not receive his prescribed medications during his second admissions when he was readmitted to hospital on 9 June. a. On 9 June a doctor in Accident & Emergency had reviewed Mr Amico's prescribed medications and increased liquid oral morphine sulphate 10 mg in 5mL Solution 4 hourly as required with 2.5 -5 mg max 6 doses at 22:57 hours with slow released morphine sulphate (MST) continued 2 times daily. Trust staff did not administer any morphine to Mr Amico although he and his family were raising concerns about his high level of pain. b. The family was informed incorrectly that medications had not been prescribed. On the morning of 10 June, the family were given permission by a nurse to dispense from Mr Amico's own supply of medications that

	he had brought to the hospital due to his level of pain. This was not accurately recorded in Mr Amico's record. Mr Amico took his prescribed morning dose of MST. c. On 10 June the nurse in Accident & Emergency did not escalate to the nurse in charge or a senior doctor that she could not locate the doctor allocated to Mr Amico and instead approached a foundation year 1 doctor to prescribe pain relief for Mr Amico. The nurse informed the doctor who was junior and very busy that the frequency of the morphine needed to be increased for Mr Amico. The doctor did not escalate the matter and did not review Mr Amico before prescribing a controlled drug. d. Neither the nurse nor the doctor sufficiently scrutinised the medication prescribed on 9 June or on the Trust system that would have shown the correct medications. This led to a prescription error being made with MST being increased from 2 times daily to 4 times daily. Mr Amico was not referred for pain management. e. Mr Amico then moved to a ward. Multiple nurses were involved in checking and administering a controlled drug morphine sulphate slow release (MST) on 5 separate occasions between 10 and 11 June 2024 and did not raise concerns about the potential for a prescription error or note that Mr Amico had already received 1 dose of MST that morning. (3) Mr Amico's NEWS score increased, and an emergency call was not put out on 11 June when it was established that Mr Amico was unresponsive even to pain from 03:00 hours . (4) The on-call doctor was called approximately one hour after Mr Amico's NEWS score was found to be 10 and arrived at 07:50, this was not an emergency call. The on-call doctor had not been informed of: a. the deterioration in Mr Amico's presentation during the night b. that the family had informed nursing staff of their concerns Mr Amico had been given the wrong medication when he was noted to be unresponsive at approximately 03:00 hours, that should have immediately raised concerns about an overdose of MST. (5) The on-call doctor escalated concerns immediately but not emergency call was put out. (6) Mr Amico morphine overdose was partially treated: a. There was an immediate response to Naloxone but the opioid reversal for overdose was not in accordance with British National
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	Formulary guidelines or with an NHS England alert previously issued. b. There was no consideration or plan for alternative pain management in a patient who had been receiving morphine pain relief as part of his treatment plan for cancer. c. Mr Amico suffered acute withdrawal syndrome and family complained about his suffering to hospital staff that they stated was not ameliorated. An emergency call would have triggered the attendance of an Anaesthetist who could have given advice on opioid reversal in a palliative patient. Princess Alexandra Hospital & NHS England (7) Multiple nurses were involved in morphine administration and all had completed their original training outside of the UK and had undertaken a Trust medicines administration training that should have recognised that the prescription of MST 4 times a day was not appropriate. Mr Amico received 6 doses of MST in less than 24 hours instead of 2. (8) Medicines administration refresher training for nurses is not mandatory and the Trust in reviewing this case has not followed a local recommendation from senior nurses for this to be included.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you and 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 12 January 2026. 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: • Family • Care Quality Commission 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	17 November 2026 HM Area Coroner for Essex Sonia Hayes