Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] NHS Derby and Derbyshire Integrated Care Board First Floor The Council House Corporation St. Derby DE1 2FS
1	**CORONER** I am Peter Nieto, senior coroner for the coroner area of Derby and Derbyshire
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 25 March 2025 I commenced an investigation into the death of Wendy BODDINGTON aged 56 (known as Wendy). The investigation concluded at the end of the inquest on 02 March 2026. The conclusion of the inquest was: - *Wendy died due to the toxic effects of taking a higher than prescribed fentanyl dose. Prescribed codeine added to the toxicity.*
4	**CIRCUMSTANCES OF THE DEATH** Wendy was found deceased at home by friends who went to check on her on 24 March 2025 after she had not responded to texts and phone calls for several days. Wendy had two fentanyl patches on her body rather than the single patch prescribed. Post-mortem examination with toxicology established that she had a high level of fentanyl in her system recognised to be in the fatal range and codeine would have added to that toxicity. Wendy had been prescribed those medications for chronic pain since 2011, following an accident and amputation of her arm. The court heard that there is now awareness of the risks of long-term prescription of opiates and opioids and fentanyl in particular, concerning complications including tolerance and dependence, with guidance issued to medical practitioners over time as understanding has increased. The fentanyl was prescribed by a GP at Wendy's GP practice in 2011 because Wendy complained that other pain relief had been ineffective. The dose was increased over a short period. At that time GP awareness of the complications of fentanyl was more limited, but in 2014 and 2015 GPs at the practice had attempted to address Wendy's level of opiate and opioid medication, although Wendy was not in agreement. However, Wendy had at least annual medication reviews, and on the evidence there were no clear plans to address this after 2015 which were missed opportunities over a nine to ten year period. There was also a

	missed opportunity for the specialist hospital pain clinic to raise the fentanyl prescription with the GP practice in 2021. The court heard that it is often the case that opiate and opioid reduction or stoppage can be difficult, and Wendy had expressed objections. There is no positive evidence that Wendy had placed two fentanyl patches on herself to deliberately harm herself, and it is noted that she had fallen and injured her ankle just days before her death and she was probably experiencing increased pain because of that.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: - The context for my concerns is the well-recognised situation of long-term prescription of opiate and opioid medications, often at high doses, for chronic pain. It is now recognised that such prescribing will usually cause other health problems, including dependence and tolerance, and over time becomes limited in controlling pain. Whilst current guidance is against such prescribing, there are many people who have been taking these medications for a long time for whom stopping or reducing the medications is very challenging. Use of those medications carries risk of accidental or deliberate overdose and death. Wendy's inquest heard that her GP practice has initiated a targeted programme to identify patients who have been receiving long-term prescription of opiate and opioid medications and engage them in focussed review to agree planned reduction, stoppage, or substitution of those medications. This programme involves 2 senior GPs and 2 pharmacists and so is a significant commitment. The practice is incrementally concentrating on those patients with high-dose prescriptions. Relatedly the practice has introduced a number of measures to try and avoid patients being inappropriately prescribed these medications for chronic pain in the first place. In evidence the GP partner stated that he was unaware of other GP practices in the Derbyshire area undertaking similar programmes. The inquest also heard that there are no specialist services for patients who have developed dependence on opiates and opioids, and that substance misuse services will only work with people with non-prescribed drug issues. The inquest did hear anecdotal evidence that NHS England may be pursuing some relevant initiatives but the details and extent of this was unclear. My specific concern is that there appear to be a significant number of people who are being prescribed opiate and opioid medications for chronic pain, often at high doses and for long periods, but may not be receiving support to reduce, stop, or substitute those medications. It appears to me that the ICB is in a position to consider this problem and potential remedies on a regional basis, and feed into national strategies.
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 April 28, 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 • Wendy's family. • Lister House Surgery. • University Hospitals of Derby and Burton. I may also send a copy of your response to any person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. She/he may send a copy of this report to any person who she/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: 3 March 2026** [redacted] **Peter Nieto** **Senior coroner** **Derby and Derbyshire**