REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Chief Executive, The Practice, Rose House, Bell Lane Office Village, Bell Lane, Little Chalfont, Amersham, Bucks, HP6 6FA** **2. [redacted] Legal Counsel and Company Secretary, The Practice, Rose House, Bell Lane Office Village, Bell Lane, Little Chalfont, Amersham, Bucks, HP6 6FA**
1	**CORONER** I am Nadia Persaud, assistant coroner, for the coroner area of East London
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 1 November 2013 I resumed and concluded an inquest into the death of Joanne Manning (date of birth 29 April 1964 – aged 49). The investigation concluded at the end of the inquest on 1 November 2013. The conclusion of the inquest was that Joanne Manning had a history of poly-substance abuse, for which she received a prescription of methadone. In the months leading up to her death she began to experience increasing breathlessness and a diagnosis of asthma was confirmed. Her methadone was continued at a relatively low dose of 25mg/ml daily. The combination of her underlying respiratory disease and the effects of the use of methadone and mirtazapine and the presence of cocaine and morphine, caused her to suffer respiratory failure, from which she died.
4	**CIRCUMSTANCES OF THE DEATH** (1) Joanne Manning had suffered from poly-substance abuse for many years and had received methadone treatment for many years. She had, in the past, received doses of up to 80mg/mls. Her final dose was reduced to 25mg/ml as the prescribing psychiatrist was aware, from the patient, that she was suffering from asthma. (2) If Ms Manning was non compliant with methadone, she would relapse to using drugs of abuse. The methadone therefore had to be continued. (3) In May 2012 she began to suffer from breathlessness and was seen by general practitioners at The Practice in Loxford. (4) A diagnosis of asthma was made in September 2012 by her general practitioner and Ms Manning was commenced on clenil modulite and salbutamol inhalers. (5) On 15 August 2012 Ms Manning presented with depression to the general practitioner and was prescribed mirtazapine. (6) Methadone was being prescribed by the psychiatric team and the general practice were aware of this by clinic letters. (7) Despite being aware of the patient receiving methadone, there was no evidence that the general practitioners had taken the methadone into account when treating the patient, or provided any advice to the patient in relation to the risks

	(8) On the 29 August 2012 the psychiatrist prescribing the methadone requested information from the general practitioner as to any further medication/treatment that the patient was receiving. (9) Despite the general practitioner considering that it was for the psychiatrist to consider the risks of methadone in a patient suffering from asthma and to advise the patient of the risks, there was no response to the psychiatrist's request for further information. The general practice did not confirm the diagnosis of asthma or the treatment with mirtazapine. The psychiatrist could not therefore make a fully informed assessment. (10) Ms Manning died as a result of respiratory failure. On the balance of probabilities, the respiratory failure was caused by the combination of methadone, mirtazapine and the presence of cocaine and morphine.
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) Methadone is to be used with caution in a patient suffering from asthma. In order for the prescriber of methadone to exercise all due caution, they would have to be fully informed of the patient's diagnosis and treatment by other healthcare professionals involved in the patient's care. (2) Evidence was heard that methadone should be used with caution in a patient who is also receiving mirtazapine. (3) The psychiatrist prescribing the methadone requested further information about the patient's medication and treatment from The Practice, Loxford. The letter from the psychiatrist was in the general practice file. It was not however responded to. (4) The general practitioner who gave evidence at the Inquest agreed that the psychiatrist should have been fully informed, but she felt that the patient could tell the psychiatrist about her diagnosis and treatment. (4) The general practitioner was unable to comment on whether it would be appropriate for a patient who often attended appointments intoxicated, to inform the psychiatrist of key clinical information. It is my view that this would not be appropriate. (5) Evidence was given at the Inquest that there was no procedure or policy in place to ensure clear lines of communication between general practitioners to secondary care providers of methadone. It was agreed by the general practitioner and psychiatrist that such a policy/procedure would be desirable to protect patients in the future.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, The Practice PLC, 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 6 January 2014. 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 - [redacted] North East London NHS Foundation Trust. I have also sent it to the Redbridge Clinical Commissioning Group who may find it useful or of interest. They may wish to disseminate the learning to wider practices. 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	**[DATE]** **[SIGNED BY CORONER]**