Robin J. Balmain
H.M. SENIOR CORONER

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BLACK COUNTRY CORONER'S DISTRICT
(SANDWELL • DUDLEY • WALSALL • WOLVERHAMPTON
Metropolitan Borough Councils)

Date: 11th June 2014 Our Ref: RJB Your Ref:

REGULATION 28 REPORTS TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO :

National Institute for Health & Clinical Excellence,
Level One
City Tower
Piccadilly Plaza
Manchester
M1 4BD

1. CORONER
I Robin John Balmain am the Senior Coroner for the Black Country Coroners Jurisdiction

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 19th February 2013 commenced an investigation into the death of **Bridget May CAHILL.** The investigation concluded at the end of the inquest on 30TH May 2014 and the conclusion of the inquest was that death was due to the effects of morphine properly prescribed ad administered.

4. CIRCUMSTANCES OF THE DEATH
The deceased died in hospital of a morphine overdose.

5. CORONERS CONCERNS
The evidence I heard was that Mrs. Cahill was admitted to Walsall Manor Hospital on 10th September 2013. She had a one day history of unresponsiveness, had a background of Parkinson's disease, dementia and chronic backache. She lived in a residential home. On admission she had pinpoint pupils suggesting morphine overdose which was partially reversed with an antidote. Blood tests showed high calcium levels suggestive of dehydration, or possibly a tumour and there was a suggestion of possible ongoing infection. She had treatment with IV fluids, IV antibiotics and Naloxone, but she deteriorated and died. She was on morphine night and morning and also oral morphine during the day if and when required. The maximum dose of Oramorph was 20 millilitres per day, 5 millilitres at a time, dosages to be 4 to 6 hours apart. The evidence I heard was that at no time prior to her death did she have the maximum permitted dose.

The **MATTERS OF CONCERN** are as follows :-

My concern relates to how it is that a person who is prescribed morphine and who has less than the amount prescribed for them, can nevertheless suffer an overdose. I write to enquire whether attention needs to be given to the maximum dose that can be recommended and whether it is, or should be, subject to factors such as body weight, any co morbidities and any other factors and whether attention should be directed towards the possible buildup of morphine in the body for those involved in long-term therapy.

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 the report, namely by **THURSDAY 7th AUGUST 2014.**

8. **COPIES and PUBLICATIONS**

I have sent a copy of my report to the Chief Coroner and to the following interested Persons :

[redacted]

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.

R.J. Balmain
Senior Coroner