CORONER FOR INNER SOUTH DISTRICT
GREATER LONDON

Southwark Coroner's Court, 1 Tennis Street, Southwark, SE1 1YD
[redacted] [redacted]

11 June 2014

Mr Matt Hoghton, Medical Director of the
Department of Clinical Innovation & Research
Royal College of General Practitioners
30 Euston Square
London
NW1 2FB

Re Inquest into the death of June Lilian Rose
DOD: 14/08/2012

Dear Mr Hoghton:

I am reporting this matter to you in accordance with The Coroners and Justice Act 2009, paragraph 7 of schedule 5, which places me under a duty to make a report in order to prevent other deaths. Rules 28 and 29 of The Coroners (Inquests) Rules 2013 set out the requirements of this provision and the requirement of the person to whom it is made to respond. I attach to this letter a copy of the relevant statutory provisions. In summary, these rules provide that where the evidence at an inquest gives rise to a concern that circumstances creating a risk of other deaths will occur or will continue to exist in the future, and in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner may report the circumstances to the person who may have power to take such action.

In this instance I am writing a report following the inquest into the death Mrs June Rose who died at her home address in Eltham, London on 14 august 2012. The inquest was heard on 28 April 2014 at the Inner London South Coroner's Court without at jury. Mrs Rose had been bed bound for several years before her death and her health was gradually deteriorating. Mrs Rose developed bed sore and was prescribed morphine sulphate using oral solution 5mg twice a day for pain relief. On 6 August 2012 Mrs Rose was prescribed fentanyl patches by [redacted] from The Mound Medical Centre delivering 100mcg/hr in error and equivalent to 360mg of morphine per 24 hours not having appreciated its morphine sulphate equivalent.* The patch was applied on 6 August 2012 and replaced 3 days later as instructed with another patch. However, this second patch was removed later that same day by a member of the Palliative Care Team when the error was discovered. Although Mrs Rose continued to deteriorate she did not die until some days later at her home address. The pathologist gave as the cause of death as:

Ia. Bilateral pneumonia
Ib. Alzheimer's disease

II. Fentanyl toxicity.

During the course of the inquest it became apparent, that although the overdose of morphine administered by way of the fentanyl patches did not directly cause Mrs Rose's death, I accepted the pathologist's evidence that:

" The drug would have had a sedating effect in an already severely ill person and was likely to have contributed towards developing a pneumonia by way of respiratory depression."

While the prescribing doctor recognised the an error was made in prescribing the fentanyl patches at that level, it became apparent at the inquest that there appears to be little training of GPs on a national level in the prescription of this and other similar morphine based pain relief medications and consequently, a lack of familiarity with the dosage required or appropriate. I heard evidence that although this particular surgery had sought to take steps to prevent this event from reoccurring, I remain concerned that there is no mandatory training or regular refresher training on a national level in the prescribing of these kinds of drugs.

Therefore, I require to be informed as to what steps are, or will be made available or required to all GPs to familiarise themselves with the prescription of these types of pain relief medications in order to prevent a potentially and directly fatal error from occurring.

In accordance with a copy of this report is being sent to the Chief Coroner as well as all the other properly interested persons identified at the inquest. A list of the copy recipients can be found at the end of his report. Your response to the report will also be shared with those listed.

The Chief Coroner may send a copy of the report and response to any person who he believes may find it useful or of interest. In addition the Chief Coroner may publish a full copy or a summary of the report and response (unless there are approaches made in respect of non-publication).
The rules require that you provide a written response within 56 days of the day the report is sent. If you are unable to respond within that time, you may apply to me for an extension. The response is to contain details of any action that has been taken or which is proposed will be taken whether in response to this report or otherwise, or an explanation as to why no action is proposed.

If there are circumstances where you do not want your full response to be shared with the copy recipients listed at the end of his report, or for a copy of it to be published, you may make a written representation to me at the time giving your response. Instead of releasing or publishing your full response it may be possible to share or publish a summary in accordance with rule 43A.
I look forward to receiving your response.

[redacted]

Yours sincerely,

Lorna Tagliavini

Lorna Tagliavini, Assistant Coroner, West London

CC: The Chief Coroner
[redacted] at The Mound Medical Centre
[redacted] (daughter) & family members