REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:
The Chief Executive Officer
East Lancashire Healthcare NHS Trust
Trust Headquarters
The Royal Blackburn Hospital
Haslingden Road
Blackburn BB2 3HH

1 CORONER

I am Michael Singleton, Senior Coroner for the Coroner area of Blackburn, Hyndburn & Ribble Valley.

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 6th December 2013 I commenced an investigation into the death of Kathleen Cornthwaite aged 76. The investigation concluded at the end of the Inquest on the 3rd June 2014. The conclusion of the Inquest was that Kathleen Cornthwaite died of cardiorespiratory failure due to combined tramadol and fluoxetine toxicity the circumstances of which being that she had been admitted to Pendle Community Hospital when following a fall on 2nd December 2013 in which she sustained an injury to her ribs her prescription for tramadol was increased. The doctor prescribing the tramadol failed to take into account her age, size and the effect of other medicines that were being prescribed such that she suffered a fatal overdose, the conclusion being that of medical misadventure.

4 CIRCUMSTANCES OF THE DEATH

Whilst an inpatient at Pendle Community Hospital Kathleen Cornthwaite was being prescribed 15mg of tramadol four times a day together with fluoxetine for depression. On the 2^{nd} December 2013 she fell sustaining a rib injury and at that time the dose of tramadol was increased to 50-100mg to be taken four times daily. The drug chart failed to indicate whether the dose dispensed was 50 or 100 such that during the period from the 2^{nd} to the 4^{th} December the dose of tramadol dispensed could have been anything between 250mg per day and 400 mg per day. For a person over the age of 75 the maximum dose is 300mg per day.

	CORONER'S CONCERNS
5	During the course of the Inquest the evidence revealed matters giving arise to concern. In my opinion there is a risk that further deaths will occur unless action is taken. In the circumstances it is my duty to report to you the MATTER OF CONCERN is as follows: -
	That the drug chart failed to indicate the precise dose of tramadol dispensed.
	That the doctor prescribing was not aware of the maximum dose of tramadol for somebody over 75 years of age and failed to take into account
	her size and frailty. 3. There was no system in place such that the doctor would appreciate the fact that in prescribing tramadol he or she ought to have had regard to other medicines being prescribed particularly in this case fluoxetine.
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 this report, namely by 12 th September 2014. I, the Coroner, may extend this 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 person, namely:
	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	18 th July 2014 Signed by:
	H M Senior Coroner for Blackburn, Hyndburn & Ribble Valley