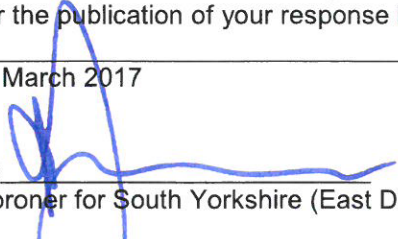




**Ms N J Mundy**  
**Senior Coroner for South Yorkshire (East District)**

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO: Group Practice Manager And Senior Partner</b> Dinnington Group Practice, The Medical Centre, New Street, Dinnington S25 2EZ</p>
1	<p><b>CORONER</b></p> <p>I am Ms Nicola Jane Mundy, Senior Coroner for South Yorkshire (East District)</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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. <a href="http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7">http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7</a> <a href="http://www.legislation.gov.uk/uksi/2013/1629/part/7/made">http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</a></p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 11/04/2016 I commenced an investigation into the death of Lyndsey Holt, 36 . The investigation concluded at the end of the inquest on 29 March 2017. The conclusion of the inquest was Natural Causes. The cause of death was 1a. Shock and haemorrhage due to 1b. Perforated Gastric Ulcer.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>Miss Holt was 37 weeks pregnant with her third child. There had been no complications during that pregnancy save that she had suffered from severe and painful varicose veins. In 2011 Miss Holt had been prescribed with methadone following a telephone conversation with the prescribing GP who considered that her reported history included reference to there having being a lengthy dependence on Codeine and also that she had taken Oxycodone and Tramadol. Specific details of the frequency of usage and amount taken could not be provided to the court. The dose of methadone had been significantly reduced during Miss Holt's second and third pregnancies. It appeared that as well as methadone, Miss Holt took paracetamol for pain relief of the varicose veins and, when particularly severe, took her partner's Oxycodone medication. On the 2<sup>nd</sup> April 2016 Miss Holt collapsed at 18:55 due to a gastric ulcer having perforated and there being catastrophic bleeding thereafter. She was conveyed by ambulance to the Rotherham Hospital. On leaving the address a pre-alert was requested from the ambulance crew via Control but Control failed to pass the pre-alert onto the receiving hospital. Had they done so clinicians at Rotherham would have been aware of Miss Holt's impending arrival, likely timing of arrival and the seriousness of the situation they were about to face. Once Miss Holt arrived at the A&amp;E Department of the Rotherham Hospital an emergency caesarean section was rapidly performed, extensive resuscitation measures put in place, she underwent a splenectomy, repair of a ruptured gastric ulcer and towards the end of her life a hysterectomy in a last ditch effort to try and save her. The overwhelming coagulopathy she had developed and shutting down of organs led to her death on the morning of the 3<sup>rd</sup> April 2016 from shock and haemorrhage due to a perforated gastric ulcer.</p>

5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <p>The circumstances in which the methadone was prescribed namely:</p> <ol style="list-style-type: none"> <li>(1) Doing so over the telephone with no face to face consultation.</li> <li>(2) Consequent lack of detail regarding: <ol style="list-style-type: none"> <li>2.1 the drugs being taken by Miss Holt</li> <li>2.2 the frequency with which they were being taken</li> <li>2.3 the degree if any, of her dependence</li> <li>2.4 absence of assessment of any psychological issues</li> </ol> </li> <li>(3) Providing a methadone naïve patient with a 7 day supply.</li> <li>(4) Lack of medical review during the initial phase.</li> </ol>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you, The Group Practice Manager And Senior Partner, Dinnington Group Practice have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 24 May 2017. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons :  <span style="background-color: black; color: black;">[REDACTED]</span> Messrs Browne Jacobson, AVMA and Messrs DAC Beachcroft.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>Dated 29 March 2017</p> <p></p> <p>Signature  Senior Coroner for South Yorkshire (East District)</p>