REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Care Quality Commission 151 Buckingham Palace Rd, Victoria London. SW1W 9SZ [redacted] General Practitioner, Lisson Grove Health Centre, Gateforth Street, London. NW8 8EG [redacted] General Practitioner, Lisson Grove Health Centre, Gateforth Street, London. NW8 8EG
1	**CORONER** I am Dr Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West 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.
3	**INVESTIGATION and INQUEST** On the 15th January 2019, evidence was heard touching the death of **Theresa Margaret Feehan.** Mrs Feehan had been found deceased at home on 12th March 2018. She was 58 years old at the time of her death. The findings of the court were as follows: **Medical Cause of Death** 1 (a) Aspiration Pneumonia (b) Ingestion of Amitriptyline and Dihydrocodeine **How, when and where the deceased came by her death:** Mrs Feehan suffered with oxygen and steroid dependant allergic asthma. This was subject to regular severe exacerbations. She was also prescribed potentially respiratory compromising medication, including amitriptyline, clonazepam and chlorpheniramine. On the 10/3/2018 she saw her GP with a further severe exacerbation of her asthma. Dihydrocodeine was prescribed in an attempt to control her pleuritic pain and respiratory distress. She had recently been prescribed morphine in hospital. On 12/3/2018 she was found at home deceased by her son, and found to have toxic levels of amitriptyline and dihydrocodeine which had contributed to her death in association with her underlying lung disease. There was no evidence of suicidal intent nor suspicious findings.

	Conclusion of the Coroner as to the death: Natural causes in combination with side effects of prescribed medication.
4	**Circumstances of the Death.** During the evidence it became apparent that the active problem list on the GP records was out of date and missing many relevant, serious medical conditions. There was little correlation between the active problem list and the list of prescribed medication. Drugs potentially dangerous to Mrs Feehan because of their respiratory depressant effects, especially when combined with other medication, such as clonazepam which had originally apparently been prescribed for restless legs, had been continued without challenge despite Mrs Feehan having had medication reviews. There was no proper recording of the reason or rationale for the dose of amitriptyline that she was taking. It was not even recorded on the active problem list that she was on home oxygen. Requests for information from the practice by the court had been managed by administrative staff and not properly responded to despite the eventual service of two summonses. This raised the concern in the evidence that other patients may not have their notes and prescribing properly reviewed and that admin staff may be undertaking tasks without proper supervision such that other clinical issues may arise and go unrecognised. The evidence suggested that the practice doctors appeared to assume that as Mrs Feehan was so often admitted to hospital her repeat medications were being reviewed by the hospital.
5	**Concerns of the Coroner:** 1. That the system of medication review within the practice is inadequate putting patients at risk. 2. That the recording and coding of relevant medical history on the active problem list is inadequate thus putting patients at risk 3. That there appears to be little correlation between the medication list and the active problem list such that it would make it difficult for a reviewing doctor to understand why a patient was on a particular medication and thus challenge its continuation or dosage appropriately, thus putting patients at risk. 4. That there appears to be no clear system for identifying medications which may interact to the detriment of the patient or no system to address such issues should they arise such as reducing or stopping redundant treatment thus putting patients at risk. 5. That administration systems within the practice should be audited to determine whether they are adequate and the work of the administrative staff sufficiently supervised, such that patients are not put at risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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] And via email to [redacted] And to Mrs Feehan's daughte[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.
9	**27th February 2019**  **Professor Fiona J Wilcox** **HM Senior Coroner Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED** **Honorary Professor QMUL School of Medicine and Dentistry**