REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Turning Point 2. Hopwood House Medical Practice, Oldham 3. NHS Oldham Clinical Commissioning Group
1	**CORONER** I am Ms Joanne Kearsley, Senior Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 10th June 2019 I concluded the Inquest into the death of Beverley Shaw. Ms Shaw died on the 11th December 2018 at her home address in Oldham. The medical cause of her death was confirmed in evidence by the Pathologist and Toxicologist as 1a) Acute Left Ventricular Heart Failure due to 1b) Ischaemic Heart Disease due to 1c) Combined use of Butane, Propane gas and Cocaine with Distal Pulmonary Embolism and mild to moderate Aspiration Pneumonia. The conclusion reached was that the deceased died as a result of a combination of some naturally occurring heart disease exacerbated by her long-standing use of butane and propane gas.
4	**CIRCUMSTANCES OF DEATH** During the course of the Inquest the Court heard evidence as to the circumstances surrounding the death of Ms Shaw who was under the care of the local substance misuse service (Turning Point). The Court heard Mrs Shaw had a number of co-morbidities in particular Trigeminal Neuralgia. As a result she was prescribed a significant amount of medication including Cocodamol, Amoxicillin, Olanzipine, Lacosamide, Amitriptyline, Duloxetine, Promazine, Pregabalin, Fragmin and Carbmazepine. In addition due to her previous heroin use she was prescribed Methadone by Turning Point. In addition Ms Shaw was known to be using illicit cocaine and also had a significant addiction to gas canisters. She was found deceased in her bed in the early hours of the 11th December 2018.
5	**<u>CORONER'S CONCERNS</u>** 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. The **MATTERS OF CONCERN** are as follows:- <u>Communication</u> o There was a lack of communication between Turning Point and the GP practice specifically in respect of Ms Shaw's use of butane gas. There was no information contained in the evidence before the Court to indicate her GP was aware of the use of butane gas, which was significant (ie 5 cans a day). This was described in evidence by Turning Point as her most significant addiction which was not amenable to treatment with medication. There was one 4 page letter dated the 15th May 2018

from Turning Point to the GP practice, in the summary section this simply recorded, "Uses *butane gas daily*." In the section headed "*Current Reported Substance Use*" there is no mention of butane gas. The remainder of this letter deals with other matters. No information was shared with the GP with regards to the amount of gas being used by Ms Shaw.

- There is no record of a response from the GP practice to Turning Point following their letter dated the 15th May 2018. This had a number of requests for actions by the GP including the sharing of any blood results (LFT, FC and U&E), together with information confirming whether there was any prescribing of drugs which may interact with methadone. There was no evidence that this information was shared or actioned.

Medication Review

- A medication review took place in the GP practice in August 208, this only documented a review of her olanzapine medication and the fact that she was in receipt of methadone and using cocaine. There is no evidence that there was a full review of all the medications prescribed to Ms Shaw. When questioned it was accepted in Court it was unclear as to why she was still being prescribed a number of medications.

Records

- The Court heard evidence that following the transition from another provider to Turning Point a decision was taken that all medical records relating to users of the substance misuse service do not need to be carried over to Turning Point. Unlike other medical records ie GP records which go with the patient when they move surgery the new substance misuse service only receives the last 6 months records hence they do not have the full past medical history available.

6 **ACTION SHOULD BE TAKEN**

In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 4th March 2019. 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:- family of Ms Shaw

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 from. 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.

Date: 10th June 2019 Signed: