REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: The Senior Partner, West Timperley Medical Centre, 21 Dawson Road, West Timperley, Altrincham, WA14 5PF

CORONER

I am Adrian Farrow, Assistant Coroner for Manchester South.

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.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 20th May 2019, an inquest was opened into the death of Deborah Chapman who died on 3rd March 2019 at [redacted] Altrincham, WA14 4LN, at the age of 54 years. The investigation concluded with an inquest which I heard on 31st July 2019 and which concluded with a Conclusion to the effect that Ms Chapman died as a consequence of a combination of prescribed and illicit drugs.

CIRCUMASTANCES OF THE DEATH

Ms Chapman was a long-term and open user of illicit drugs. She had ceased to inject these drugs intravenously and for some time prior to her death inhaled crack cocaine and heroin in particular.

She had significant damage to her left hip joint, which caused her significant pain and, at the time of her death, was awaiting a hip replacement operation for which she sought and was prescribed strong opiate pain relief medication.

Ms Chapman also had an underlying COPD condition, which had been the subject of hospital review and treatment in November 2018 and January 2019, The hospital were aware of an discharged Ms Chapman on each occasion with the pregabalin and oxycodone prescriptions.

Those prescriptions had already been in place prior to Ms Chapman re-joining the West Timperley Medical Centre as a patient in July 2018 and were reviewed by the practice in August 2018.

She continued to misuse crack cocaine and heroin. Ms Chapman continued to request the pain relief prescribed drugs from her GP.

On 27th February 2019, a friend moved into the house with Ms Chapman. She was able to observe that Ms Chapman was taking the prescribed medication and also using heroin. On 2nd March 2019, Ms Chapman's daughter and mother visited her at home. It was clear to her daughter that she had taken illicit drugs. Ms Chapman's daughter fed and bathed her mother, leaving her at about 11.00pm in the company of her friend.

Ms Chapman's friend retired to bed with Ms Chapman and woke on 3rd March to find that Ms Chapman was unresponsive. Paramedics were called but death was pronounced at 7.06am.

A post mortem examination concluded that Ms Chapman died as a consequence of:

1)a) Combined toxic effects of heroin, oxycodone and pregabalin; and

2) Chronic obstructive pulmonary disease

CORONER'S CONCERNS

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. –

1. I heard evidence from [redacted] representing the West Timperley Medical Centre. He acknowledged that the known side effects of both pregabalin and oxycodone, both individually and concomitantly, presented a risk of having a depressive effect on the respiratory system. He also acknowledged that Ms Chapman's COPD represented an underlying compromise of her respiratory system.

2. The evidence I heard from the records held at the medical centre did not reveal the extent to which any enquiry was made of Ms Chapman as to her current misuse of illicit drugs either on the occasion of her re-joining the medical practice as a patient in July 2018 or at subsequent consultations. There were clear signs of a dependence on the prescribed opiate drugs and the medical records equally revealed long-term illicit opiate misuse.

3. The evidence I heard from the medical records held at the medical centre did not reveal, beyond the admitted dependence on the prescribed medication, what enquiry had been made from Ms Chapman in relation to her continued misuse of illicit drugs or her response to those enquiries.

4. In the absence of that information, it was not possible, from the medical records, to ascertain what level of risk the continued illicit misuse of opiates posed to Ms Chapman and therefore, whether, on an informed basis, pregabalin and oxycodone were appropriate prescriptions.

5. Furthermore, the evidence did not reveal any system in place at the West Timperley Medical Centre to ensure that the information about illicit drug misuse is obtained and recorded from patients in order to ensure that an informed assessment of the risks of the concomitant use prescribed and illicit drugs could be made and reviewed.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by **26th September 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

COPIES and PUBLICATION

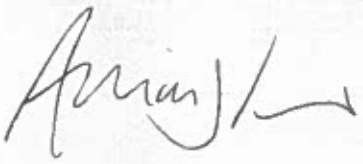
I have sent a copy of my report to the Chief Coroner and to [redacted] on behalf of the family.

I have sent a copy of my report to the Care Quality Commission who may find it useful or of interest.

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.

Dated: 1st August 2019.



Signature: Adrian Farrow HM Assistant Coroner, Manchester South.