REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] Chief Medical Director, Turning Point
1	**CORONER** I am Catherine McKenna, Area 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 27 February 2020, I commenced an investigation into the death of **Natalie Jane Edgington.** The investigation concluded at the end of the inquest on 11 January 2021 when I returned a Narrative Conclusion, 'The Deceased died as a result of a complication of prescribed medication.' The medical cause of death was: 1a) Methadone toxicity 1b) Fatty liver disease 2) Liver cirrhosis
4	**CIRCUMSTANCES OF DEATH** Natalie Edgington was 28 years old when she died at her mother's address on 24 February 2020. Ms Edgington had a history of chronic liver disease and had been discharged from Gastroenterology services in October 2019 due to her non-attendance at liver clinic appointments. The Deceased was on a repeat prescription for codeine phosphate for abdominal pain secondary to liver problems and the evidence was that consideration had previously been given to the prescription of spironolactone for ascites. On 8 January 2020, the Deceased self-referred to Turning Point in Rochdale for support with opiate dependency. She was assessed by a nurse prescriber who noted her chronic liver disease and wrote to her GP on 22 January 2020 requesting any recent blood tests. There is no evidence that the GP responded to this letter or that a liver function test was requested by Turning Point. On 29 January 2020, the Deceased was prescribed a titrating dose of methadone progressing from 30 mls to 60 mls over the course of 9 to 12 days. The Deceased's mother contacted Turning Point on 11 February 2020 to inform them that the Deceased had been vomiting for 5 days and was too unwell to collect her methadone. Alternative arrangements were made for the collection of the prescriptions. The Deceased did not attend an appointment that was offered by the GP on 11 February or respond to a message left by her recovery worker on 20 February. The Deceased was found dead at her mother's address on 24 February 2020. She died of the effects of an accumulation of methadone which she had been unable to properly eliminate due to an impairment of her liver function.
5	**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. That prescribers should have full information about the nature and extent of a service user's liver disease in order to ensure that prescribing is within safe limits. The prescription to the Deceased was issued without relevant medical information that could have been obtained from the GP and/or an up to date liver function test. There is a risk associated with reliance on a service users self-reporting of his/her own medical history particularly against a background of non-attendance at medical appointments. 2. The BNF recommends that consideration should be given to starting patients with a history of liver disease on a lower dose of methadone than the standard starting dose of 30mls. There was no evidence to suggest that any consideration was given to starting the Deceased on a lower dose.
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 **9 March 2021**. I, the Area 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 namely:- • [redacted] (mother of the Deceased) • Hopwood Medical Centre, 1-3 Walton Street, Heywood, OL10 2BS 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.
9	Date: 11 January 2021 Signed: C Mackenzie.