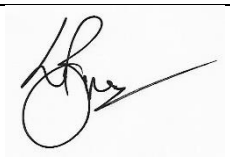
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. East Suffolk and North Essex NHS Foundation Trust**
1	**CORONER** I am Lincoln Brookes, Area Coroner for Essex.
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 16/08/2019 I commenced an investigation into the death of June Patricia Margaret PARLOUR (then aged 74). The investigation concluded at the end of the inquest on 22/09/2020. The conclusion of the inquest was: Medical Cause of Death: I a Opiate Toxicity b c II Disseminated carcinoma of unknown primary. Narrative Conclusion: On 11 May 2019 at Colchester General Hospital, Turner Road, Colchester, Essex, June Patricia Margaret PARLOUR died of opiate toxicity following administration of morphine doses that cumulatively amounted to an inadvertent and fatal overdose. She had been an inpatient, suffering from disseminated terminal cancer, and the overdose hastened her death significantly. The overdose occurred as a result of a breakdown in communication between staff and was contrary to both hospital and national guidelines.
4	**CIRCUMSTANCES OF THE DEATH** Mrs June Parlour was an inpatient at Colchester General Hospital, Turner Road, Colchester, Essex, suffering from, amongst other matters, disseminated terminal cancer which had spread to her liver but had yet to

	be considered for a palliative pathway. At around 12.30am on 11/5/2018 she was prescribed and given 10mg of Oramorph (oral liquid morphine) for abdominal pain and was given a further 10mg dose of morphine intravenously. Both of these doses where in excess of national BNF guidelines and indeed those of the hospital (and in terms of the IV dose being untitrated). Mrs Parlour was particularly vulnerable to the effects of morphine by reason of her advanced age, her opiate naivety and her compromised liver. Mrs Parlour's condition deteriorated and she was given Naloxone to reverse the over-sedation. She was then placed on a palliative pathway, administered a further 2mg of morphine and died later that morning of opiate toxicity. It was the finding of the Court that the overdoses had significantly hastened her death.
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 could 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) During the course of the hearing it became apparent that staff on the ward (whether doctor or nurse) were not familiar with either the national morphine guidelines (BNF) or indeed those of the hospital. The Court is concerned that such lack of awareness may not be limited to that ward or that hospital. (2) It was concerning that even the hospital's own Serious Incident report had incorrectly quoted the hospital's guidelines as to the safe dose of IV morphine and that neither the investigatory team or any of the clinical staff who subsequently read that report had picked up on this. (3) I am concerned as to the adequacy of education re safe morphine doses that newly qualified doctors and locum doctors receive, and how this is audited. 4) I am concerned that the hospital's own guidelines regarding morphine administration for acute pain management have not been revised since 2013 and are at odds with the current BNF guidelines (in terms of appropriate doses and patient vulnerability). 5) I was concerned that this incident arose as a result of a doctor and a nurse failing to understanding each other, and the nurse subsequently feeling that she had no choice but to administer an IV dose that she believed to be dangerous, and in particular that: a) The drug charts design did not facilitate clear instructions for titration for one-off doses of IV morphine. b) The nurse did not feel confident enough to challenge the prescription (as she perceived it) effectively or escalate / refer to another doctor.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 by 4pm 24/11/2020. 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] (family of the deceased) 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	 **28/9/2020** **LINCOLN BROOKES – AREA CORONER FOR ESSEX**