VERONICA HAMILTON-DEELEY, LL.B.
Her Majesty's Senior Coroner
for the City of Brighton & Hove

Assistant Coroners
CATHARINE PALMER LL.B (HONS)
KAREN HENDERSON, BSC,BM,MRCPI,FRC..
GILVA D.J.TISSHAW, BA(LAW)HONS

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CORONERS SOCIETY OF ENGLAND AND WALES

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REPORT IS BEING SENT TO: 1. **[redacted] H R Healthcare Limited, V Jame 1 – 1100, Prague 1. Czech Republic.** 2. **[redacted] H R Healthcare Limited, The Office, Britannia Way, Bolton. Lancashire. BL2 2HH.** 3. **Professor Sir Bruce Keogh, KBE, MD, DSc, FRCS, FRCP, National Medical Director, NHS England, Skipton House, 80 London Road, SE1 6LH.**
1	**CORONER** I am Veronica HAMILTON-DEELEY, Senior Coroner, for the City of Brighton and Hove
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 24th August, 2016 I commenced an investigation into the death of Philip Richard David BREATNACH otherwise Richard BREATNACH. The investigation concluded at the end of the inquest on 24th August, 2016. The conclusion of the inquest was **MISADVENTURE (DEPENDENCE ON DRUGS)**

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4	**CIRCUMSTANCES OF THE DEATH** See Record of Inquest
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. – (1) Mr Breatnach (and anybody else) is able to apply online for medications (2) That applying online, if the application form is not thoroughly checked , allows the applicant to lie or give false or misleading answers to critical questions which is what Mr Breatnach did. (3) There was no evidence that the prescriber made any effort to contact Mr Breatnach's GP to find out if the answers that he gave were true. (4) Prescribing Dihydrocodeine, a potentially addictive drug, used for the treatment of moderate to severe pain to a patient who the prescriber has never seen appears to fly in the face of good prescribing practice. (5) The amount of Dihydrocodeine prescribed appears to be excessive. (6) I understand from the evidence that I heard at the Inquest that Dihydrocodeine should not be prescribed for migraine which is the reason Mr Breatnach gave for asking for this medication. (7) The instructions were that the Dihydrocodeine should be taken every four to six hours as required. The evidence at the Inquest was that taking Dihydrocodeine in this way, potentially suggesting that eight tablets could or should be taken every twenty four hours until the whole of the one hundred and twenty six tablets given are used up is I heard not the way Dihydrocodeine should be prescribed. (8) Prescribing this number of tablets would therefore seem to be completely inappropriate and fails to understand that medications such as Dihydrocodeine can be used as currency. The medication came in three packets – one containing one hundred tablets and the other two containing twenty eight tablets each. The two packets containing twenty eight tablets

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	each were never found and this raises the possibility that Mr Breatnach was able to sell them, although I have no evidence that he did. (9) This way of prescribing completely undermines the diligent and careful GP's efforts to control this man's medication over use.
6	**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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **2nd December 2016**. 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 1. [redacted] 2. [redacted] 3. Secretary of State for Health, Department of Health 4. Simon Stevens, Chief Executive NHS England 5. National Patient Safety Agency I have also sent it to:- 6. [redacted], General Pharmaceutical Council 7. [redacted] Royal Pharmaceutical Society 8. [redacted] General Medical Council 9. [redacted] Sussex Police 10. [redacted] GP Brighton Who may find it useful or of interest.

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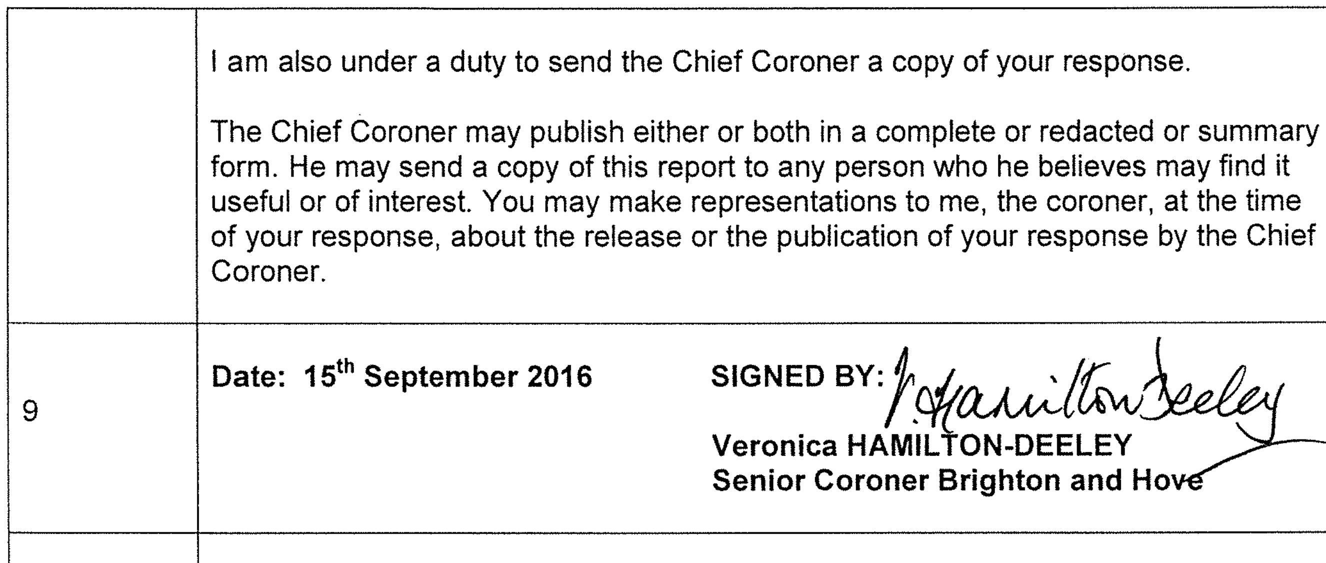

	I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Date: 15th September 2016** **SIGNED BY:** [signature] **Veronica HAMILTON-DEELEY** **Senior Coroner Brighton and Hove**