Ms N J Mundy
Senior Coroner for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Practice Manager** Manor Field Surgery, Braithwell Road, Maltby, Rotherham, S66 8JE
1	**CORONER** I am Ms N J Mundy, Senior Coroner for South Yorkshire (East District)
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 14/12/2016 I commenced an investigation into the death of Craig Stuart Hamilton, 36 . The investigation concluded at the end of the inquest on 13 June 2017. The conclusion of the inquest was Prescribed drug related death. Craig Stuart Hamilton died at [redacted] Maltby on 8 December 2016 after ingesting excess Tramadol medication in an attempt to relieve his chronic pain which unintentionally led to his death from acute tramadol toxicity
4	**CIRCUMSTANCES OF THE DEATH** Mr Hamilton suffered a serious assault in 2009 leading to permanent and serious damage to his right leg. Part of the residual problems included chronic pain for which he received Tramadol from 2009 until the time of his death. It became clear from the evidence I heard that despite the prescribed rate (which was the maximum recommended by BNF for effective pain relief) in 2009, Mr Hamilton had effectively self medicated to the extent that he was taking almost double that dose on a regular basis from 2009 until the time of his death. Mr Hamilton died from Tramadol toxicity after taking excess amounts with the intention of controlling the pain sufficient that he could sleep during the night before working the next day. He did not take excess amounts with the intention of causing any self harm or ending his life.
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) Absence of clear procedures to manage patients who routinely access larger amounts of medication than actually prescribed. (2) Absence of clear procedures to monitor and manage patients who endeavour to obtain repeat prescriptions such that it takes them beyond the prescribed dosages. (3) Absence of clear procedures to fully explore drug regimes and alternative forms of pain management at annual medication reviews. (4) Consideration for improved systems for discussing with patients the implications of them attempting to exceed prescribed dosages and recording that such discussions have taken place.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you The Practice Manager, Manor Field Surgery 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 08 August 2017. 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] 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	Dated 13 June 2017 Signature_____ Senior Coroner for South Yorkshire (East District)

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