IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Hayley Denise Sheehan
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** 1. [redacted] 2. [redacted] Practice and Business Manager The Moat House Surgery Worsted Green Merstham Surrey RH1 3PN
2	**CORONER** Ms Anna Crawford, HM Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
4	**INVESTIGATION and INQUEST** An investigation was commenced on 28 November 2016 and the inquest into the death of Hayley Denise Sheehan was opened on 9 January 2017. It was resumed and concluded on 26 July 2017. The medical cause of death was found to have been: 1a. Tramadol toxicity. The inquest concluded with a short form conclusion of 'Accident'.
5	**CIRCUMSTANCES OF THE DEATH** Mrs Sheehan suffered from fibromyalgia. She was a patient at the Moat House Surgery in Merstham, where she received a repeat prescription for 112 200mg slow release Tramadol tablets every two months, to be taken twice a day.

On 22 November 2016 Mrs Sheehan collapsed and died at her home address, having unintentionally overdosed on her prescription Tramadol. The medical cause of her death was found to be 1a. Tramadol toxicity. [REDACTED] the Forensic Toxicologist, gave evidence that the levels of Tramadol present in Mrs Sheehan's system were consistent either with her having taken 25 tablets shortly before her death or, alternatively, with her having taken her prescribed dose more than twice a day over a more prolonged period of time.

[REDACTED], a GP partner at the Moat House Surgery, told the court that during the period from 9 February to 7 November 2016 Mrs Sheehan had regularly requested her repeat prescription for Tramadol early and as a result she was able to obtain a total of 896 tablets as opposed to the 560 tablets which were envisaged by her repeat prescription, an excess of 336 tablets. With regards to the last prescription before her death, Mrs Sheehan received a prescription of 112 tablets on 7 November 2016, despite her next prescription not being due until the beginning of December 2016.

[REDACTED] told the court that patients' requests for repeat prescriptions are dealt with by prescription administrators who receive the request and then prepare the prescription for a GP to sign. The system in place is such that in the event that a patient requests a prescription too early, the administrator should draw the request to the attention of a GP, who then makes a decision with regards to whether or not to authorise it.

Having considered the evidence, the court found that Mrs Sheehan's requests for early prescriptions had not been identified, or acted upon, during the course of 2016, and that as a result she had been able to obtain a significant amount of excess medication.

[REDACTED] told the court that following Mrs Sheehan's death the prescription administrators have been trained to highlight early requests for repeat prescriptions to GPs. He also said that new procedures have been introduced in respect of the prescription of Tramadol, and that in particular the Surgery now only prescribes it as an acute prescription, as opposed to a repeat prescription. [REDACTED] told the court that the Surgery was considering introducing similar measures in respect of other controlled medicines.

6	CORONER'S CONCERNS The **MATTERS OF CONCERN** are: - The procedure for issuing repeat prescriptions relies heavily upon the prescription administrators identifying and flagging early requests to GPs. As far as [redacted] was aware, the software used by the surgery does not automatically identify early prescription requests. Consideration should be given to introducing more safeguards to ensure that early requests for repeat prescriptions are identified and drawn to the attention of a GP. This should include giving consideration to whether the relevant software can be adapted to automatically identify early prescription requests.
7	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
8	YOUR RESPONSE You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
9	COPIES I have sent a copy of this report to the following: 1. [redacted] 2. [redacted] 3. [redacted] 4. The Chief Coroner In addition to this report, I am 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, at the time of your response, about the release or the publication of your response by the Chief Coroner.

10	**Signed:** **ANNA CRAWFORD** **DATED this 1st day of August 2017**