REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Professor Stephen Powis – National Medical Director NHS England**
1	**CORONER** I am Lydia Charlotte Brown, Assistant Coroner for the Exeter and Great Devon 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.
3	**INVESTIGATION and INQUEST** On 14th December 2017 I commenced an investigation into the death of Karl James Willis, DOB 19 May 1986. The investigation concluded at the end of the inquest on 17 August 2018. The conclusion of the inquest was Medical cause of death – **1a Aspiration Pneumonitis** **1b Amitriptyline and morphine toxicity** **Conclusion - Misadventure**
4	**CIRCUMSTANCES OF THE DEATH** Karl had been taking substantial amounts of prescribed medication and was under regular review and twice weekly medication collection with an intention to prevent excessive intake/overdose and to gradually reduce his dependency. A short time before his death, the GP had removed amitriptyline from his prescribed medications and replaced this with another drug, explaining the two should not be taken together. Karl completed and online questionnaire with UK meds and was untruthful in most aspects of the information he disclosed, in order to secure a further online prescription of amitriptyline. He also refused permission for his GP to be advised of this prescription request. Karl was found deceased at home and the toxicology confirmed the concentration of amitriptyline in the blood specimen is well above that seen after therapeutic dosage and within the reported fatal range. The concentration of morphine is sufficient to have significantly increased toxicity due to the amitriptyline.
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) Amitriptyline is well recognised to have toxic effects when taken in excessive amounts or in conjunction with other medication

	(2) Permitting the patient to "self certify" without any checks he can appropriately access this medication can allow the patient to give inaccurate answers, and therefore the questionnaire is open to deliberate abuse by those most vulnerable who have addiction problems (3) Permitting the patient the option of not having the GP informed removes an otherwise effective safeguard. The GP had worked with extreme care and supported the patient over many months to try and reduce his excessive reliance on polypharmacy.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 **19th October 2018**. 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 **Ms Samantha French,** [redacted] **and** [redacted] I have also sent it to **UK Meds, Care Quality Commission, National Patient Safety Agency and General Medical Council** who may find it useful or of interest. 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** 24 August 2018 **Signed** ..... **Lydia C. Brown** **H. M. Assistant Coroner for Exeter and Greater Devon** **Room 226** **County Hall** **Topsham Road** **EXETER** **Devon EX2 4QD**