	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], **Chief Inspector Primary Medical Services & Integrated Care, Care Quality Commission** 2. **Ms Nadine Dorries, Minister of State for Patient Safety, 39, Victoria Street, London, SW1H OEU**
1	**CORONER** I am Mr Andrew Cox, the Acting Senior Coroner for the coroner area of Cornwall and the Isles of Scilly.
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 2nd February 2021, I concluded an inquest into the death of Katie Emma Corrigan who died on 9th August 2020 then aged 38. . The medical cause of death was recorded as: 1a) Excess consumption of Codeine I recorded a Conclusion of a drug-related death.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Corrigan had a long history of chronic pain from a neck complaint together with anxiety and depression. She developed an addiction to pain-relieving medication, notably Zapain. At inquest, it was accepted in evidence by her GP that there had been occasions when Mrs Corrigan had been prescribed too much medication and also periods when she had requested repeat prescriptions prematurely. When the weaknesses in the GP prescribing system were identified, the GP refused to prescribe further Zapain without a discussion with Mrs Corrigan. She refused to engage with the GP and no further prescriptions were issued by the practice for Codeine or other opiates after 20/4/18. It was also heard in evidence that Mrs Corrigan had been found to have forged prescriptions during her employment as a Practice Nurse at a surgery in Penzance in order to obtain further prescription medication illicitly. This led the NMC to strike her off the Nursing Register. It became clear during the inquest that Mrs Corrigan had continued to source Codeine and (it is believed) Amitriptyline (as well as other prescriptions, eg, Propanolol and Modafinil) after April 2018. From packaging recovered by her GP after an admission to hospital in 2019 it is believed Mrs Corrigan obtained this from a number of on-line pharmacies, including: Halliwell Late Night Pharmacy on 22/8/19 – Codeine Phosphate The Independent Pharmacy 0n 11/11/19 – Propanolol. It is highly likely that other on-line pharmacies may have been approached. The identity of the doctor(s) who gave Mrs Corrigan a script for the medication, (notably Codeine or other opiates) has not been established but it was heard in evidence that her

	registered GP had not been contacted by any other doctors who are likely to have been approached privately by Mrs Corrigan.
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. – The GP who gave evidence at the inquest, Dr [redacted] from Bodriggy Health Centre in Hayle, stated that she had never been contacted by another doctor considering the prescription of opiate or other medication to Mrs Corrigan. She was able to procure the medication in sufficient quantities first to require an emergency admission to hospital and latterly to result in her death. Similarly, the registered GP was not contacted by any dispensing pharmacist checking whether the prescription was appropriate. After Dr [redacted] became aware of the two on-line pharmacies who had dispensed the medication to Mrs Corrigan that led to her admission into hospital, she attempted to raise an alert through NHS England, in order that the undesirability of prescribing opiate medication to Mrs Corrigan could be raised with clinicians. This was sent out regionaly but Dr [redacted] has since been advised there is no formal procedure for circulating Patient Alerts to pharmacies on a national level. I am further given to understand that non NHS contacts would only receive a redacted version of the alert in any event. What seems clear is that the alert proved ineffective in preventing Mrs Corrigan from improperly obtaining sufficient quantities of opiate medication to result in her death.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. The absence of a requirement for doctors in the private sector to contact a registered GP prior to dispensing opiate medication to a patient leaves the system open to abuse. One of the on-line pharmacies identified above openly advertises itself as offering a 'discreet' service which I interpret as a willingness to circumvent the existing, inadequate controls. I do not know but am bound to wonder if there is a professional or financial relationship between the prescribing doctor and dispensing pharmacist and, if so, whether this is considered ethical or meeting current professional standards? The Alert system appears cumbersome and ineffective. Subsequent to the inquest, I have spoken to [redacted], Lead Controlled Drugs Accountable Officer, Medical Directorate, NHS England & NHS Improvement (South West.) His view is that the following further steps could be taken. • Some less regulated controlled drugs ('schedules 4 and 5'), should be regulated to a greater extent. Specifically, opioids that are prescription only medicines such as codeine tablets and morphine oral solution should be regulated as schedule 3 drugs, as has already happened with tramadol and pregabalin. This would introduce new controls that would make them much harder to access inappropriately. This would require a change in controlled drugs regulation by the Home Office. Ideally the same would be done with benzodiazepines and steroid hormones. • If the above is not an option then the controls in place for Schedule 2 and 3 controlled drugs *prescribed privately* should be extended to Schedule 4 and 5

	controlled drugs such as codeine so there is oversight of what is being prescribed and by whom. This would require a change in controlled drugs regulation by the Home Office. • All online prescribing services accessible by patients in England should be regulated by the CQC, regardless of which professional groups are doing the prescribing, regardless of where in the world those prescribers are registered, and regardless of where in the world the provider's head office is. This would require a change in regulation by the Department of Health & Social Care. • Change the status of codeine linctus from a pharmacy medicine to a prescription only medicine. This would require a change in regulation by the Department of Health & Social Care
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 16/4/21. 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] (parents); [redacted] (brother and sister-in-law; Dr [redacted] (GP), [redacted] and Cornwall Partnership Foundation Trust. 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	**17th February 2021** Andrew Cox Acting Senior Coroner