Regulation 28: Prevention of Future Deaths report

Tracy Frances MCCARTHY (died 15 July 2023)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The GP Partners** **The Tredegar Practice** **35 St Stephen's Road** **London** **E3 5JD**
1	**CORONER** I am Ian Potter, assistant coroner, for the coroner area of Inner North London.
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 1 August 2023, an investigation was commenced into the death of TRACY FRANCES MCCARTHY, then aged 50 years. The investigation concluded at the end of an inquest, heard by me, on 15 May 2024. The inquest conclusion was 'drug-related death'. The medical cause of death was: 1a amitriptyline toxicity II coronary artery disease
4	**CIRCUMSTANCES OF DEATH** Tracy McCarthy was found deceased at her home address on 17 July 2023. She died as a result of her long-term misuse of 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 could 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) Although Amitriptyline is not generally regarded as a drug of abuse, Ms McCarthy was known to be dependent on it. She had been prescribed Amitriptyline for many years, and at one stage in or about 2022, she was regularly prescribed [redacted] mg per day, which is over the maximum suggested dose in the BNF (150mg per day). In addition, the BNF provides a clear warning (as did the prescribing/records software in use at The Tredegar Practice) that Amitriptyline prescribed for depression (which it was in this case), is "not recommended – increased risk of fatality in overdose". A GP from The Tredegar Practice told me that [redacted] mg was an "unacceptable dose". The concern being that guidelines were not followed, particularly in relation to a patient known to be dependent and where use of Amitriptyline was not recommended for the presenting condition in any event. (2) Following Ms McCarthy's admission to hospital as a result of an overdose of Amitriptyline and Codeine, The Tredegar Practice received information from the hospital, making reference to the overdose. Despite this, the risk was not flagged and no alert was put on the system; as such, the prescription of Amitriptyline continued. A GP from The Tredegar Practice told me, "[the Amitriptyline] should have been stopped, but knowing [the patient] that would have been very hard to do." (3) Ms McCarthy's Amitriptyline prescriptions had previously been issued on a daily basis, to mitigate the risk of overdose. However, following her admission to hospital (mentioned above) a GP at The Tredegar Practice took the decision to reduce the dose slightly, but transfer to monthly prescriptions, thereby allowing Ms McCarthy access to 28 days' worth of Amitriptyline all at once. A GP from The Tredegar Practice told me that they thought this was "risky" but said that the GP who made that decision was not familiar with the patient and maybe wouldn't have known the rationale for daily prescriptions. They also told me that the Practice was probably "over-reliant on the knowledge of particular doctors that treated her." The concern is that too great an emphasis was placed on the knowledge of a few individuals, which led to acknowledged risks not being put in the records in a way that would alert any practitioner to them.
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 16 July 2024. 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 this report to the Chief Coroner and to the following Interested Person: (a) [redacted] – daughter of the deceased I have also sent a copy to following, for information: - The Care Quality Commission. 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	**Ian Potter** **HM Assistant Coroner, Inner North London** **21 May 2024**