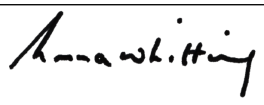
Senior Coroner - Emma Whitting
Bedfordshire & Luton
REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: Sir Andrew Dillon, Chief Executive NICE, 10 Spring Gardens, London, SW1A 2BU
1	**CORONER** I am, Emma Whitting, Senior Coroner for Bedfordshire & Luton
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 Twenty-Second June 2018 I commenced an Investigation into the death of Graham Martin SAFFERY aged 48. The investigation concluded at the end of the inquest on Twelfth September 2019. The conclusion of the inquest was Narrative Conclusion: *The Deceased died as a result of taking a combination of Oxycodone and Amitriptyline prescribed to him by health professionals. The combination of the drugs is known to carry a risk over-sedation. Despite exhibiting signs of over-sedation particularly following a doubling of his Amitriptyline dose on 23 May 2018 his prescription remained unaltered.* Ia Respiratory Depression Caused By Oxycodone and Amitriptyline Overdose
4	**CIRCUMSTANCES OF THE DEATH** Following a road traffic accident in November 2015, the Deceased was prescribed Oxycodone from October 2016. He was also diagnosed with depression in January 2018 for which he was prescribed Amitriptyline 10 mg. On 16 April 2018, his depression was classified as severe and he was also diagnosed with PTSD and his Amitriptyline was increased to 75 mg daily. Although his pharmacist reported him looking drugged and confused on 26 April 2018, on 23 May 2018, his amitriptyline dose was increased to 150 mg daily. On 27 May 2018, he was admitted to Bedford Hospital with reduced GCS. He was treated in ITU but was not referred to the Psychiatric Liaison Team and his prescribed medications were re-started on the morning of 29 May 2018. On 13 June 2018, his Pharmacist again expressed concern about his presentation as did his family but his medication remained unchanged. He was found deceased at his home on the afternoon of 19 June 2018. Post-mortem examination revealed a blood concentration of oxycodone 0.25 mg/L and amitriptyline 1.4 mg/L (nortriptyline 1.7 mg/L).

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 : Although other pharmacological guidance such as *Medscape Drug Interaction Checker* and *Stockley's Interaction Checker* recommend the need for both **caution** and **monitoring** when prescribing amitriptyline and oxycodone simultaneously, such advice does not appear to be provided by the BNF which is regularly consulted and relied upon by GPs.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you as Chief Executive 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 13 November 2019. 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: Queens Park Health Centre, ELFT, Bedford Hospital and [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	 Emma WHITTING Senior Coroner for Bedfordshire and Luton Coroner Service

	Dated: 18 September 2019