Coroner ME Hassell
HM Senior Coroner
Inner North London

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: [redacted] Clinical Director – St Bartholomew's Hospital Bart's Health NHS Trust Ground Floor, Pathology and Pharmacy Building, The Royal London Hospital, 80 Newark Street, London, E1 2ES
1	**CORONER** I am: Assistant Coroner Sarah Bourke Inner North London Poplar Coroner's Court 127 Poplar High Street London E14 0AE
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 10 December 2018, Senior Coroner Mary Hassell commenced an investigation into the death of Kenneth John Daly aged 51 years. The investigation concluded at the end of the inquest which was conducted by me on 3 October 2019.

	The conclusion of the inquest was that Mr Daly's death was drug related. The medical cause of death was: 1a multi-drug toxicity (Morphine, Dihydrocodeine, Codeine) My short form conclusion was that: "Mr Daly had longstanding problems with chronic back pain and anxiety. He was prescribed multiple medications for this. Following review by pain management specialists, it was decided that Mr Daly's opioid medications would be reduced to Morphine and Co-Codamol. However, he continued to be issued with Dihydrocodeine prescriptions. Mr Daly overdosed on Morphine, Dihydrocodeine and Codeine which was taken alongside prescribed Pregabalin and benzodiazepine medication. Mr Daly was found deceased at his home on 4 December 2018."
4	**CIRCUMSTANCES OF THE DEATH** Kenneth Daly had problems with chronic pain in his lower back and legs following an accident in 2000. He also had peripheral neuropathy, degenerative disc disease, coronary artery disease and anxiety. Pain had a substantial impact on Mr Daly's quality of life and affected his ability to undertake activities of daily living. Mr Daly had been using Fentanyl patches (100 mcg/hour) for pain relief. He wanted to stop using Fentanyl because of its impact on his quality of life and memory. His GP had reduced the dosage to 75 mcg/hour. Mr Daly then noted that his physical function had deteriorated. Mr Daly was also prescribed Dihydrocodeine, Amitriptyline, Pregabalin and Tramadol for pain relief and Venlafaxine, Olanzapine, Diazepam and Temazepam for his mental health. Mr Daly was known to change the amounts of medication that he took depending on how he felt at particular times. His GP decided to refer Mr Daly to pain management specialists in 2017 for guidance on pain management with a particular intention of reducing the use of opioid medications. In January 2018, the Consultant in Anaesthesia and Pain Management initially recommended reducing Fentanyl further to 50 mcg/hour and additionally prescribing Tapentadol. He was also referred for physiotherapy. Mr Daly did not find the changes to medication helpful and continued to use Dihydrocodeine and Tramadol. In July 2018, Mr Daly attended a further appointment with his Consultant at the medication management clinic. It was noted that he reported high levels of pain, anxiety and depression and low levels of health related quality of life. It was decided to stop Fentanyl altogether and start Morphine Sulphate MR 60mg twice per day with Co-Codamol 30/500mg for breakthrough pain. The pain management specialist's view was that no other opioids were to be taken once Morphine Sulphate and Co-Codamol had been prescribed but that prescribing of Pregabalin could continue. Mr Daly's GP continue to issue prescriptions for Dihydrocodeine and Tramadol at reduced quantities from the amounts issued in the past. In the later part of

	2018, his GP also referred him to see specialists as he reported having a number of falls. The cause of the falls had not been identified at the time of Mr Daly's death. On 4 December 2018, Mr Daly was found dead at his home. Toxicology analysis found Morphine, Dihydrocodeine, Codeine, Pregabalin, Diazepam, Temazepam, Paracetamol, Venlafaxine, Amitriptyline and Olanzapine in Mr Daly's system. From the toxicology analysis, it is evident that Mr Daly had taken more than the prescribed dose of Morphine, Dihydrocodeine, Pregabalin and Co-Codamol prior to his death. The Toxicologist's evidence was that Morphine, Dihydrocodeine and Codeine all belong to the same class of drugs and when taken in combination, their effects are additive. One of the main side effects of opiates is respiratory depression i.e. a suppression of the body's ability to breathe which can be potentially fatal. Pregabalin can increase the respiratory depressant effects of opioid medications. Diazepam and Temazepam can also enhance the respiratory depressant effects of opioid medications.
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) In oral evidence, the Consultant stated that no other opioids were to be taken once Morphine Sulphate and Co-Codamol had been prescribed but that prescribing of Pregabalin could continue. She set out her advice in a letter to Mr Daly's GP dated 11 July 2018. The letter clearly stated that Fentanyl and Tapentadol should be stopped and Morphine sulphate (MST) 60mg started. The advice regarding the prescribing of pain relieving medications other than Fentanyl and Tapentadol is less clear. In relation to Dihydrocodeine and Tramadol it is stated that "*He can continue using the Dihydrocodeine and very rarely Tramadol until he sees you for his next prescription. Together with the MST, I would recommend to allow him Co-Codamol 30/500mg 2 tablets up to four times a day…".* Following receipt of the letter, Tramadol and Dihydrocodeine continued to be issued by the GP practice albeit at lower quantities than previously prescribed. The GP did not seek any further guidance regarding the advice given in the letter of 11 July 2018 from the Consultant. 2) Mr Daly was a patient that was known to adjust his pain medication without seeking guidance from his GP. Whilst Mr Daly was copied in to the letter sent to his GP on 11 July 2018, he was not given any written guidance regarding his pain relief and the use of other medications (such as benzodiazepines) that was tailored to his needs as a patient.

	Specifically, he was not given any written advice regarding the risks of using multiple opioid medications in combination.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 18 December 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 a) [redacted] b) [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.
	Sarah Bourke **Assistant Coroner** **23 October 2019**