For the urgent attention of Prescribers and Dispensers of Controlled Drugs:

There have been two deaths in the East of England that have resulted in the Coroner issuing a Regulation 28 letter to the NHS.

Please read the information below and consider for any patient/script you encounter.

1. **Amitriptyline and Oxycodone**

Mr. Saffery was prescribed Oxycodone and subsequently Amitriptyline – the dose of the latter was increased over the following months. Although his pharmacist reported him looking drugged and confused, his amitriptyline dose was increased. Following an admission to Hospital with reduced GCS, he was treated in ITU and his prescribed medications were re-started. Concerns were raised again by the pharmacist and family, but his medication remained unchanged. He died as a result of this combination of prescribed oxycodone and amitriptyline.

Using Oxycodone together with Amitriptyline can increase the risk of serotonin syndrome, symptoms include confusion, hallucinations, seizures, extreme changes in blood pressure, increased heart rate, fever, excessive sweating, shivering or shaking, blurred vision, muscle spasm or stiffness, tremor, incoordination, stomach cramp, nausea, vomiting, and diarrhoea. Severe cases may result in coma and death.

Although guidance recommends the need for both caution and monitoring when prescribing amitriptyline and oxycodone simultaneously, the coroner noted that this guidance does not appear to be provided by the BNF.

Please take this opportunity to review patients on, and prescriptions for this combination.

Please highlight these patients for a medication review as soon as possible. Please remember that medications can be accessed via the NHS, privately, online and via other routes – Ask them what they are taking.

2. **Codeine over the internet / over the counter**

Mrs Headspeath was prescribed Dihydrocodeine for back pain. She developed a tolerance to this taking much higher doses than is normally prescribed by purchasing combinations of Codeine with Ibuprofen/Paracetamol over the internet.

Her GP prescribed the higher doses of Codeine, so she could avoid taking toxic quantities of ibuprofen or paracetamol – this prescribing was insufficient to meet her dependant needs and she continued to supplement her prescription with OTC medications containing Codeine.
There have been changes in the way online pharmacies prescribe and/or supply opioids. They should not be prescribed unless the patient consents to share information with the GP\(^i\). This guidance is similar to GMC Good Medical Practice guidance\(^ii\).

Please remember when prescribing and/or supplying any medicine that you may not be aware of prescribing/supplies from other sources despite the above regulatory guidance.

It is important to note that Codeine and Dihydrocodeine are **Schedule 5 Controlled Drugs**\(^iv\) and as such are exempt from virtually all Controlled Drug requirements other than retention of invoices for two years.

Please take opportunities to review patients who are being prescribed schedule 4/5 Controlled Drugs – remember to ask what medications they are taking from elsewhere.

There are multiple opportunities to review medications and risk of harm. We can all contribute to this.

The WHO has a Medication Safety tool with patient leaflet etc\(^v\) which can be applied at different levels of care and in different settings and contexts. i.e. when patients:

- visit a primary health care facility;
- are referred to another health care facility or to another health care professional;
- visit a pharmacy;
- are admitted to a health care facility;
- are transferred to another health care facility;
- are discharged from a health care facility;
- receive treatment and care at home or nursing home

---

Dr Sarah Rann

**Controlled Drugs Accountable Officer**

**NHS England & NHS Improvement, East of England, Medical Directorate**

West Wing, Victoria House, Capital Park, Fulbourn, Cambridge, CB21 5XE

Tel: 01138 250770

Email: england.ea-cdao@nhs.net

---

\(^i\) [https://www.judiciary.uk/subject/prevention-of-future-deaths/](https://www.judiciary.uk/subject/prevention-of-future-deaths/)

\(^ii\) [https://www.pharmacyregulation.org/sites/default/files/document/guidance_for_registered_pharmacies_providing_pharmacy_services_at_a_distance_including_on_the_internet_april_2019.pdf](https://www.pharmacyregulation.org/sites/default/files/document/guidance_for_registered_pharmacies_providing_pharmacy_services_at_a_distance_including_on_the_internet_april_2019.pdf)


\(^v\) [https://www.who.int/patientsafety/medication-safety/5moments/en/](https://www.who.int/patientsafety/medication-safety/5moments/en/)