

# REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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#### THIS REPORT IS BEING SENT TO:

- 1. Department of Health
- 2. Medicines and Healthcare Products Regulatory Agency

#### 1 CORONER

I am Lisa Hashmi, Assistant Coroner for the coroner area of Manchester North

#### 2 CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013

### 3 INVESTIGATION and INQUEST

On the 9<sup>th</sup> September 2013 I commenced an investigation into the death of Victoria Meppen-Walter then aged 44 years of the investigation was concluded at the end of the inquest on the 11<sup>th</sup> February 2014.

The conclusion of the inquest was that the deceased had taken her own life.

The medical cause of death being 1a) Chloroquine Toxicity

### 4 | CIRCUMSTANCES OF DEATH

In September 2011, the deceased underwent a dermatological procedure at a private hospital. Immediately thereafter, she complained of having been left in/with constant unbearable nerve pain, 'pins and needles' to her face/upper body and to her mind, unsightly scarring.

She lost confidence and became reclusive. The outcome of the surgery had a profound impact upon her mental health (which had previously been unremarkable). There was ongoing decline and Mrs Meppen-Walter was subsequently diagnosed as suffering from an adjustment disorder with depressive symptoms and somatoform pain disorder. She was offered counselling but did not engage.

In 2012, she started researching assisted suicide and contacted organisations – both in the UK and abroad.

On the 30<sup>th</sup> September 2013 the deceased's husband had not seen his wife for a couple of days. Whilst the couple did not see each other daily, such was their lifestyle, the possibility that the deceased had decided to travel abroad for assisted suicide.

The police were contacted and an investigation commenced.

On the 1<sup>st</sup> September 2013, Mrs Meppen Walter was found deceased in the locked front living room of the family's home, with a 'do not resuscitate' note and a bowl with white powder residue close by.

A post mortem examination was carried out and the medical cause of death given as above.

It is unclear how the deceased obtained sufficient chloroquine to bring about her death.

## 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 availability and regulation of chloroquine
	&
	2) The risk of associated misuse
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.
7	YOUR RESPONSE
	You are under a duty to respond to this report within 56 days of the date of this report, namely Friday 25 <sup>th</sup> April 2014. I the Assistant 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 namely the family of the deceased
	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 from. He may send a cop 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.
a	27 <sup>th</sup> February 2014 Signed: