	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Dr John Elliston MBE, Chief Executive of the 700 Club, Darlington, Co Durham**
1	**CORONER** I am Crispin Oliver, Assistant Coroner, for the Coroner area of County Durham and Darlington
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. (see attached sheet)
3	**INVESTIGATION and INQUEST** On 14 June 2013 I commenced an investigation into the death of Richard Philip WHITE. The investigation concluded at the end of the inquest on 5th February 2014. The conclusion of the inquest was findings were that Mr White died at Darlington Memorial Hospital on 9th June 2013, having previously taken an overdose of cyclizine at 700 Club, Hope House, Darlington ("Hope House") and the conclusion of the Inquest was that he had died as a result of misadventure.
4	**CIRCUMSTANCES OF THE DEATH** a. Richard White became a resident at Hope House on or about 15th or 16th May 2013. 700 Club is a charity which provides at Hope House, and St George`s Hall, supported hostel accommodation and support for vulnerable people with substance misuse issues or alcohol issues. On the 17th May Richard received a prescription for 21 cyclizine 50 mg tablets at Neasham Road Surgery, Darlington. On 6th June 2013 he received a prescription for 84 cyclizine 50 mg tablets plus 10 zopiclone 7.5 mg tablets at the same surgery. The zopiclone is a "sleeping pill" and the cyclizine was prescribed in relation to nausea. Richard had a history of previous attempts at self-harm, including one shortly before being admitted to Hope House, of which the staff there were aware at time the prescriptions were obtained. b. At the appointment on 6th June 2013 with [redacted] Mr White attended with his mother, [redacted] and his Support Worker from 700 Club, [redacted] During the Inquest [redacted] gave evidence that she believed all of the medication she prescribed, cyclizine and zopiclone, would be kept secure by Hope House staff andthat had she known that this was not the case she would probably not have prescribed as much of the cyclizine as she did. [redacted] gave evidence that he was concerned only about the "sleeping pills" (zopiclone) being looked after by Hope House staff. [redacted] gave evidence that she, like [redacted] had the impression that the medication would be kept secure by Hope House. [redacted] manager of Hope House, gave evidence that the policy of 700 Club is that medication is self-administered by the residents and only secured upon the request of the residents themselves and retained with their consent. She stated that she did not known where this policy was written down or kept. c. After the appointment Mr White, his mother and [redacted] attended the pharmacy where the medication was collected. [redacted] took the zopiclone and placed it in the office of Hope House for Richard subsequently to access it. Mr White took possession of the cyclizine, from the outset. On 9th June 2013 Richard White presented to staff at Hope House and announced that he had taken 104 cyclizine tablets and 7 or 8 zopiclone tablets. In spite of the best endeavours of the staff and paramedics, he

	subsequently died as a result of cyclizine toxicity.
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. – 1) That the policy of Hope House with regard to the administration and holding by staff of medication was not made known to [redacted] when she wrote the prescriptions; 2) That the policy was not provided in a protocol, or policy statement, to [redacted], or indeed, [redacted] and [redacted] 3) That no such protocol or policy statement was available.
6	**ACTION SHOULD BETAKEN** In my opinion action should be taken to prevent future deaths and I believe you,on behalf of the 700 Club 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 25th April 2014. 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 I have also sent it to [redacted] Chair of the Board of Trustees of the 700 Club, [redacted] (Service Manager of the 700 Club), [redacted] (Richard White`s Mother), [redacted] (care of the Neasham Road Surgery, Darlington) and [redacted] (Practice Manager of Neasham Road Surgery) who may find it useful or of interest. 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	**Dated……** **Signed by ……..**