ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Clinical Commissioning Group - Devon** **2. Local drugs and alcohol team**
1	**CORONER** I am Lydia Brown assistant coroner, for the coroner area of Exeter and Greater Devon
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 23rd July 2013 I commenced an investigation into the death of Andrew john Hooper 44 years. The investigation concluded at the end of the inquest on 14 May 2014. The conclusion of the inquest was Misadventure with the cause of death being- 1a Respiratory Failure 1b Hypoxic Brain Injury 1c Methadone Toxicity
4	**CIRCUMSTANCES OF THE DEATH** Mr. Hooper died due to methadone toxicity. He was a naïve user, and had taken a bottle of his girlfriends [redacted] prescribed medication that was freely available at her home address. Although [redacted] was aware of this, she made no attempt to summon medical assistance for many hours until it was too late and Mr Hooper died from 1a respiratory failure 1b hypoxic brain injury 1c methadone toxicity
	<u>CORONER'S CONCERNS</u> 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) The medication was not secured, and was prescribed in sufficient quantity for a fatal dose to be taken by a user un-used to this medication. (bottle 420ml) (2) the person to whom it was prescribed appeared to be unaware of the dangers of this

	medication, when taken by another in large quantities. (3) Consideration should be given to the appropriateness of prescribing to an individual who is not able or prepared to keep the medication safe and secure, or is not aware of the dangers of ingestion, (deliberate or otherwise), for others. If this means daily prescription, the balance of inconvenience versus the safety of others should be carefully weighed on an individual basis, and evidence recorded in this regard.
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 by 29th August 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 to the following Interested Persons – [redacted] daughter), [redacted] (father), Zak Hooper (son) and [redacted] (sister). 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	**[DATE]** 9/7/14 **[SIGNED BY CORONER]**