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. South West Ambulance Service**
1	**CORONER** I am Dr Elizabeth Ann Earland, HM Senior Coroner for the Exeter and Greater Devon District.
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. [redacted]
3	**INVESTIGATION and INQUEST** On 10th December 2012 I commenced an investigation into the death of Clare Louise BAIN, aged 40. The investigation concluded at the end of the Inquest on 1st August 2014. The conclusion of the inquest was 'Drug Related Death'. On the evening of the 4th December 2012 the Deceased, who was prescribed Methadone and Valium, ingested a fatal quantity of prescribed and non-prescribed Methadone and Valium at 68 Millway Avenue, Axminster, after having been resuscitated at 00.24 hours 5th December 2012 with Naloxone with good effect she later succumbed.
4	**CIRCUMSTANCES OF THE DEATH** Deceased on prescribed Methadone when on the evening of the 4th December 2014 she was found collapsed on a mattress on the floor at 68 Millway Avenue, Axminster, at 23.55 hours. South West Ambulance called and Mr Nicholas Clarke, Paramedic, arrived at 00.11 hours and diagnosed Methadone overdose. He administered Naloxone to good effect so much so that Deceased declined an offer to go to hospital and paramedics left her in care of neighbours until Husband returned at 04.00 hours. At 07.06 the Deceased had a cardiac arrest and South West Ambulance called, arrived at 08.05 to discover Deceased had apparently succumbed to effects of Methadone, Despite CPR by Husband and neighbour then paramedics with drugs of resuscitation it was too late and death pronounced at 08.43 5th December 21012. Cause of death: Toxic effects of Methadone and Diazepam.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) That given Deceased had declined to go to hospital the paramedics were under the impression that this was a heroin overdose and the use of one dose Naloxone was sufficient to counteract the effects of the opiate. (2) If paramedics are unaware that the respiratory depressive effects of Methadone last longer that the antagonism afforded by Naloxone there is a danger of further deaths because lack of repeat treatment doses of Naloxone when opiates are still active.
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. (1) Review training of Paramedics in giving opiate antagonists (2) Consider a more robust protocol for dealing with respiratory depressant effects of opiates to include mandatory admission to hospital until the effects have passed and drugs metabolised.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by [DATE]. 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 [NAMES] [and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)]. I have also sent it to [NAMED PERSON] 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.
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5th August 2014	**Signed** ..... **Dear Elizabeth A Earland MB.Ch.B., D.A.,Dip.Law,L.P.C,Hon.LLD** **HM Senior Coroner** **Room 226** **County Hall** **Topsham Road** **EXETER** **Devon EX2 4QD**