	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **Re Samuel Duckworth, case ref 01545-14** **THIS REPORT IS BEING SENT TO:** **The Secretary of State for Health, Rt. Hon Jeremy Hunt, Richmond House, 79 Whitehall, London SW1A 2NS**
1	**CORONER** I am Dr Andrew Harris, Senior Coroner, London Inner South
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	**INQUEST** On 23rd July, I opened an inquest into the death of: **Samuel Duckworth, aged 34 years, died 05.06.14** I concluded the inquest at a full hearing on 14th October 2014. The medical cause of death was Diazepam, Codeine and Alcohol intoxication. The court found that he died from a drug and alcohol related death.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances were recorded as: *Mr Duckworth was found dead at 16.56 on 05/06/14 in his flat having taken an overdose of Diazepam, Codeine and alcohol. He was an anxious man with poor impulse control and did not intend to take his life. The Diazepam was purchased on the internet.*
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 **MATTER OF CONCERN** is as follows. – Mr Duckworth had consulted a psychiatrist and offered help with alcohol withdrawal and psychological therapies for mood swings, anxiety and impulse control. He was only prescribed a small amount of Diazepam, which I infer is because of the risks of abuse. Yet he had no difficulty in purchasing these prescription only drugs on the internet, 20 empty packets being found at the scene. No evidence was admitted as to whether such access could be restricted or regulated. The ease of access clearly constitutes an on going risk to the lives of other vulnerable people, whose medication should be medically supervised.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the Secretary of Sate may have or know who has 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 10th December 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. If you require any further information or assistance about the case, please contact the case officer, [redacted]
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted] (father), [redacted] (partner). 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]** 20th October 2014. **[SIGNED BY CORONER]**