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.** The Right Honourable Theresa May, Home Secretary, The Home Office, 2 Marsham Street, London, SW1P 4DF
1	**CORONER** I am Alan Peter Walsh, HM Area Coroner, for the Coroner Area of Manchester West
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 3rd July 2014 I commenced an Investigation into the death of Jason Houghton, 24 years, born on the 12th October 1989. The Investigation concluded at the end of the Inquest on the 17th March 2015. The Medical cause of death was: 1a) Combined Toxic Effects of Ketamine, Heroin, Diazepam and Dextromethorphan. The conclusion of the inquest was Misadventure.
	CIRCUMSTANCES OF THE DEATH 1. Jason Houghton died at Room 124, Leigh Sports Village Hotel, Atherleigh Way, Leigh, Wigan on the 30th June 2014. 2. Prior to this death Jason Houghton has been a Registered Paramedic with the North West Ambulance Service but on the 26th February 2014 he resigned from his position and he was known to have an addiction to Benzodiazepines. 3. Jason was known to be obtaining Benzodiazepines and medical equipment from suppliers using the internet but there was no evidence that Jason used his Paramedic Licence to obtain supplies, nor did he obtain any supplies from the North West Ambulance Service. 4. Jason was known to obtain equipment, including syringes and cannulae

from Medtree using the internet and he obtained supplies of drugs from the Pakistani Health and Care Mall using the internet.

5. On the 30th June 2014 Jason was found on the bed in Room 124 at the Leigh Sports Village Hotel with a cannula inserted in his foot attached to a 'home made' drip consisting of a bag of Sodium Chloride (0.9%) that was connected by a long, thin, flexible tube into the cannula.

   On a small table next to the bed there were two syringes and four sterile eye wash solutions. The smaller syringe was empty and connected to a Hypodermic Needle whilst the second was a larger syringe that was not connected to a hypodermic needle and the second syringe was full of a clear solution.

   On the floor by the side of the bed was a small bin which contained a sealed plastic bag; on top of the plastic bag there were three discarded vials of Valium and the sealed plastic bag contacted ten further vials of Valium, as well as a quantity of used needles and syringes.

6. There was no evidence at the Inquest that Jason had ever used Heroin at any time during his life but evidence was given that he had used Benzodiazepines, including Diazepam, and Ketamine at various times prior to this death.

7. Evidence was produced at the Inquest in the form of order confirmations and invoices from the Pakistani Health and Care Mall which showed that Jason had obtained the following drugs by use of the Internet:-

   i. Calypsol Ketamine Hydrochloride
   ii. Valium (Diazepam)
   iii. Ketamax
   iv. Diacetyl Morphine
   v. Morphine Sulphate
   vi. Ritalin (Methylphenidate Hydrochloride)
   vii. Xanax
   viii. Ketarol

8. The above drugs were ordered by use of the internet and the drugs were delivered to Jason's home address, via 'Hong Kong Shipping', by post in padded envelopes.

   A selection of the drugs was delivered to Jason's address after his death and his father opened the envelope to find the drugs within the envelope.

9. When Jason placed the orders by using the internet he did not have to either identify himself or give any reasons for the use of the drugs and there were no checks in relation to the contents of the envelope upon entry to the United Kingdom and prior to receipt by him.

   The information at the Inquest was that the drugs were imported from Hong Kong and the order forms state the shipping method to be 'Hong

Kong Shipping'.

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. During the Inquest Evidence was heard that:

    i. Diacetyl Morphine is another name for Diamorphine, which is another name for Heroin. The above evidence was given by [redacted], who is the Deputy Director of Pharmacy and Medicines Governance at Central Manchester University Hospitals NHS Foundation Trust and who provides advice to the North West Ambulance Service in relation to the application of medicines Legislation and the use of medicines by Paramedics in a pre-hospital setting.

    The Diacetyl Morphine was provided in 'Pill' form and the suggestion at the Inquest was that the Pill could be dissolved and used intravenously, although it was not known whether Jason had used Diacetyl Morphine in that manner, but the Diacetyl Morphine would explain the presence of Heroin in Jason's blood at the time of his death, bearing in mind there was no evidence that he had previously used Heroin.

    ii. The evidence indicated that Jason had also received a supply of some of the drugs in the form of samples provided by sources using the internet, although it was not possible to identify the specific drugs which had been supplied as a sample.

    iii. There is no regulation of the supply of drugs by use of the internet and there is no protection in place in relation to the importation of drugs using the internet with delivery from an international source to a United Kingdom postal address by use of the postal system.

    iv. The evidence raised concerns that future deaths will occur unless action is taken to review the above issues, particularly in view of the supply of illicit Class A Drugs, being Heroin, in the form of Diacetyl Morphine, by use of the internet.

2. I request for you to consider the above concerns particularly in regard to the following:-

    i. The supply and importation of Class A Drugs, in the manner and in form described in this report, by use of the internet.

    ii. The regulation of the internet, if possible, in relation to the

	supply of drugs and the delivery of the drugs using International Shipping and the United Kingdom postal system.	
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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 25th May 2015. 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:- 1. [redacted] – Mother of Jason Houghton 2. [redacted] – Father of Jason Houghton 3. [redacted], Solicitor, Weightmans Solicitors – Solicitor on behalf of North West Ambulance Service 4. [redacted], Solicitor, Hill Dickinson LLP –Solicitor on behalf of 5 Boroughs Partnership NHS Foundation Trust 5. [redacted], Solicitor, DAC Beachcroft LLP – Solicitor on behalf of [redacted] General Practitioner. 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** **30th March 2015**	**Signed** **Alan P Walsh**