Regulation 28: REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

Paul Bennett, Chief Executive Officer
The Royal Pharmaceutical Society
66 East Smtihfield
London
E1W 1AW

1 CORONER

I am Crispin OLIVER, Assistant Coroner for the 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.

3 INVESTIGATION and INQUEST

On Nineteenth March 2020 I commenced an investigation into the death of Claire RICHARDS aged 34. The investigation concluded at the end of the inquest on Twentieth November 2020. The conclusion of the inquest was Drug related:

I a Toxic Effects of Pregabalin and Buprenorphine

I b

I c

II

4 CIRCUMSTANCES OF THE DEATH

Claire Richards had a history of drugs misuse and mental health issues. She was pronounced dead at home. She had been snorting illegally dealt pregabalin and buprenorphine in the days before her death. She became very unwell, then unresponsive. Eventually those she was with summoned the emergency services, but she could not be saved and died at home. She did not intend her own death.

5 CORONER'S CONCERNS

The MATTERS OF CONCERN are as follows:

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. This is notwithstanding that the concern is one concerning something which is endemic, and this case simply provides a paradigm example. It is my statutory duty to report to you.

The **MATTER OF CONCERN** is as follows. –

(1) This case involves a death resulting from illegally dealt prescription drugs. It is of

increasing concern that prescription drugs are available in vast quantities for illegal dealing to vulnerable people.

(2) What steps are projected, or are actually in the pipe line, for stemming the leakage of prescription medication out of the lawful dispensing process into criminal hands?

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 18 January 2021.However, given the time of year and the current national health emergency I propose to extend that to 26th of January 2021. 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],

……

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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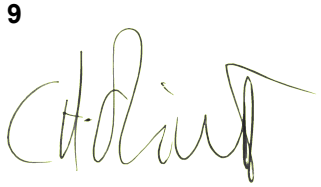

Crispin OLIVER
Assistant Coroner for
County Durham and Darlington
Dated: 23 November 2020

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