Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** Manager of Boots, Consett: [redacted] Director of Human Kind: [redacted]
1	**CORONER** I am Jeremy Chipperfield, Senior Coroner for the coroner area of 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 23 June 2021 I commenced an investigation into the death of Claire COPELAND Aged 41. The investigation concluded at the end of the inquest on 04 March 2022. The conclusion of the inquest was that: On around 17th June 2021, following a break in the continuity of her treatment for drug addiction, the deceased consumed drugs, including heroin. Claire's was a drug-related death.
4	**CIRCUMSTANCES OF THE DEATH** Claire Copeland had a history of heroin use and had received opiate substitution therapy in the months leading to her release from prison on the afternoon of Friday 11th June 2021. She was given that Friday's dose upon release and it was planned that she would collect further doses on the following Saturday and Sunday from Boots the Chemist, Consett. Current procedure involves delivery of a physical prescription document. Agents of humankind communicated with an employee at Boots to arrange delivery of the necessary prescriptions covering the weekend. A paper version of Claire's prescription was brought to Consett for delivery that Friday after Boots had closed for the day and Humankind's agent attempted to effect delivery via a letter box near Boots' shopfront; that letter box did not belong to Boots so Claire could not obtain her medication for the weekend. No attempt had been made to confirm effective delivery. The missing prescription was noted by Boots' pharmacist when Claire attempted to collect it on the Saturday; at this time Humankind was closed and there was no ready means of obtaining a further prescription.

	The agreed system contained no fail-safe provisions ensuring continuity of care in the event of failed delivery of prescription.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: Arrangements to which you are a party: • rely upon delivery of a physical prescription document; • allow that delivery be neither witnessed nor confirmed; • lack effective mechanism immediately to detect failed delivery; and • lack mechanism to remedy failed delivery; and thereby presents danger to life in that it is capable of causing discontinuity of important medical treatment.
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 May 03, 2022. 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] • [redacted] I have also sent it to [redacted]: CEO Boots UK [redacted]: CEO Humankind Charity who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

	I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 08-Mar-22**  **JEREMY CHIPPERFIELD** **Senior Coroner for** **County Durham and Darlington**

END