IN THE SURREY CORONER'S COURT

IN THE MATTER OF: GAVIN PETER PEDLEHAM

The Inquest Touching the Death of Gavin Peter Pedleham

A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • [redacted], **Chief Executive of the National Institute for Health Care Excellence** • [redacted]**CBE Chief Executive of the Medicines and Healthcare Products Regulatory Agency** • **The Right Honourable Suella Braverman KC MP Secretary of State for the Home Office** •
1	**CORONER** Caroline Topping HM Assistant Coroner, for the County of Surrey
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** The inquest was opened on the 12th May 2022 and resumed and concluded before a Coroner on the 9th December 2022. The cause of death was Morphine and Ethanol Toxicity The Coroner found that Gavin Peter Pedleham inadvertently drank a dose of oramorph

	at a family Christmas event which, in combination with the alcohol he had consumed, led to his death at home at 45, Hurst Green Road, Oxted on the 26th December 2021. The Conclusion was that he met his death by Accident.
4.	**CIRCUMSTANCES OF THE DEATH** Gavin was present at a family Christmas party on the 25th December 2021. One of the guests present at the party suffered from chronic back pain for which he was prescribed, inter alia, oramorph, on a PRN basis. This was prescribed in accordance with national guidelines at 300ml dispensed on a monthly basis. The oramorph was taken to the party for the guest to use for pain relief. It was placed in the kitchen and drunk from a glass. A dose [redacted] poured out and inadvertently left in the glass. Gavin, who had consumed a significant quantity of alcohol, drank it by mistake. The following morning, he was found dead on the sofa. The conclusion was that Gavin met his death by accident.
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 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. – The evidence showed that: 1. Oramorph is a controlled drug the storage, handling and administration of which in institutional settings is highly regulated. However, there are no similar regulations which govern its use in a community setting. There is no requirement for the recipient of the drug in the community to keep it in a safe place and ensure that it cannot be accessed by others.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation 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 24th February 2023. 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.
9	**Signed:** **Caroline Topping** **Dated this 30th December 2022.**