IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Victoria STOREY
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • The Right Honourable Suella Braverman KC MP, Secretary of State for the Home Department, • The Right Honourable Alex Chalk KC MP, Lord Chancellor and Secretary of State for Justice, Ministry of Justice,
1	**CORONER** Ms Anna Loxton, HM Assistant Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	**INVESTIGATION and INQUEST** The inquest into the death of **Victoria STOREY** was opened on 24th January 2023. Evidence was heard and the inquest was concluded on 26th June 2023. I found the medical cause of death to be: 1a. [redacted] Toxicity I determined that Victoria took an accidental overdose of [redacted], a potent synthetic opioid not licensed for medicinal use. Victoria had a history of opioid dependency, exacerbated by historic necessary medicinal use and to alleviate Post Traumatic Stress Disorder following a traumatic assault aged 18. I did not find any evidence she had intended to take her own life. The source of the [redacted] could not be traced despite Police interrogation of her electronic devices. I recorded a short form conclusion of Drug Related.
4	**CIRCUMSTANCES OF THE DEATH**

	Victoria was found deceased in her bedroom on the evening of 3rd September 2022. Toxicology found she had low therapeutic levels of prescribed drugs; a higher level of Venlafaxine consistent with chronic (not acute) dosage and [redacted] of [redacted] in her post mortem blood; which the Toxicologist stated "contributed more than minimally, and possibly substantially, to the cause of Ms Storey's death". [redacted] containing [redacted] were found in Victoria's bedroom. The Pathologist recorded a cause of death of 1a) Mixed drug (mainly [redacted]) toxicity). Having considered the Toxicology evidence in respect of the other drugs being at low levels, save for Venlafaxine which was stated to be at a level consistent with chronic dosage, I amended the cause of death to 1a) [redacted]Toxicity. I heard evidence from a Drug Expert with Surrey Police that [redacted] is not sold under that name, but is often marketed as one of the common pharmaceutical opiates, so the danger of taking this illegal substitute would not be known to the end user.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are: - Victoria had a history of opioid dependency to assist with her mental health struggles. She had previously admitted to healthcare professionals purchasing illicit opioids from the internet and there was evidence of this from 2019 and 2020 on her electronic devices. - [redacted] is illicitly traded and marketed as common pharmaceutical opiates. It has potent analgesic effects but is not approved for medicinal use due to the increased risk of adverse events. - The Home Office requested advice from the Advisory Council on the Misuse of Drugs (ACMD) on the appropriate domestic control of [redacted], and was advised by the ACMD on 18th July 2022 that [redacted](and other similar compounds) should be placed in schedule 1 of the Misuse of Drugs Regulations 2001 and listed as Class A drugs under the Misuse of Drugs Act 1971. However, at present the Act and Regulations have not been amended to include [redacted] and it is unclear if and when this will take place. [redacted] is not therefore currently controlled under Class A, Schedule 1, Misuse of Drugs Act 1971 despite its heroin-like effects with a high risk of fatal overdose. - Due to the nature of the trade in potent synthetic opiates, there is no way for the end user to know what the illicit substance

	contains. Consideration should be given to whether any steps can be taken to address the above concerns.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to the following: 1. See names in paragraph 1 above 2. [redacted] 3. The Chief Coroner In addition to this report, I am 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 at the time of your response, about the release or the publication of your response by the Chief Coroner.
	Signed: **ANNA LOXTON** **DATED this 30th day of June 2023**