REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] The Right Hon. Lucy Frazer KC MP, the Secretary of State for Digital Culture, Media and Sport The Right Hon. Victoria Atkins MP, the Secretary of State for Health and Social Care
1	**CORONER** I am Miss I THISTLETHWAITE, His Majesty's Assistant Coroner for the coroner area of Rutland and North Leicestershire.
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 20 February 2023 I commenced an investigation into the death of Nigel Walter DIXON aged 64. The investigation concluded at the end of the inquest on 4 June 2024. The conclusion of the inquest was: Drug related death The cause of death was established as: I a Morphine and Zopiclone Toxicity I b I c II
4	**CIRCUMSTANCES OF THE DEATH** Mr Dixon was a 64 year old male who lived alone. A visitor to his property was unable to rouse him on Monday 13 February 2023. Entry was gained by the Fire Service and Mr Dixon was found dead inside.

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: **Pre-amble** Mr Dixon was a 64 year old male, an army veteran who served his country as part of an elite unit. He had a past medical history including physical and mental health issues including depression, suicide attempts, being sectioned, chronic alcohol misuse and an opiod dependence. Mr Dixon's GP monitored him closely in the community and they worked together to reduce the number of prescription drugs Mr Dixon was taking, stopping the prescribing of Zopliclone then Diazepam. Mr Dixon was in the process of being weaned off morphine with the support of his GP when he was admitted to hospital on 3 February 2023 for an opiate overdose. Whilst an inpatient Mr Dixon had an abrupt cessation of his morphine use. Mr Dixon was discharged from hospital on 7 February 2023. The hospital discharge letter was not actioned and Mr Dixon was able to access one weeks' worth of morphine which had been prescribed to him and the prescription post-dated prior to his stay in hospital. Mr Dixon was found dead at home on 13 February 2023 and at post-mortem his cause of death was found to be 1a) Morphine and Zopiclone Toxicity. Mr Dixon was able to access one weeks' worth of morphine from his community pharmacy when he was discharged from hospital due. I heard evidence at inquest of improvements to the use of a system at the University Hospitals of Leicester NHS Trust, PharmOutcomes, which will, on the balance of probabilities, prevent this situation arising again by ensuring that the Hospital Pharmacist communicates the cessation of drugs like morphine to community pharmacies. Mr Dixon was honest with his GP about the fact he purchased drugs online to supplement his prescriptions. In August 2017 he advised his GP that he was taking [redacted] Zopliclone tablets every two weeks, this is 6 times the licenced amount of Zopiclone. Mr Dixon was not being prescribed Zoplicone at the time of his death, his GP stopped prescribing it to him in 2017. Mr Dixon's family provided me with documentary evidence of him purchasing drugs online before he died, one of those documents is a receipt dated 1 February 2023 [redacted]. I found, on the balance of probabilities, that the Zopliclone in Mr Dixon's system at the time of his death was supplied by [redacted] **Concerns** Mr Dixon was able to purchase [redacted] Zopliclone tablets [redacted] online from a company [redacted] The GP who gave evidence at the inquest described this as a "*huge"* amount of the drug. She

	confirmed that she would only prescribe 28 days' worth of [redacted] tablets in one go ([redacted] Mr Dixon was able to purchase). The selling of tablets which are a larger dose and in a much larger quantity than would ordinarily be prescribed online risks an accidental or intentional overdose of the drug and also risks the drug being sold on the black market. The evidence of the GP is it is hard to prescribe safely to people who are supplementing their prescription drugs with online purchases. Further, she raised concerns about the safety and quality control of the drugs being supplied. The evidence of the GP was that the company who supplied these drugs to Mr Dixon did not contact the GP Practice to discuss their suitability or check Mr Dixon's medical history, nor did they inform the GP's Practice of the purchase. I have concerns about the dosage of the tablets purchased by Mr Dixon which are larger than those that a GP would prescribe, and also the quantity of the tablets that Mr Dixon was able to purchase. It is gravely concerning that powerful drugs are available online so freely and in such large quantities, with little to nothing in the way of checks and balances around who the drugs are being sold to. There seems to be no regulation of the supply of these drugs and that seems to me to inevitably put the lives of vulnerable people at risk. In this case there was no communication with Mr Dixon's GP and I would imagine there is no way for these online companies to check whether their customers are placing duplicate orders with other websites, there seems therefore to be a situation where one could purchase almost limitless amounts of these drugs with no checks or balances at all. There seems to be no system for establishing the suitability of the purchaser, nor a system to limit the amount or frequency of medication being purchased. In short, there was no protection offered to Mr Dixon by the online company who sold him these, and other drugs, and it is clear that the drugs purchased from the company have contributed to his death. I understand that other Coroners have raised concerns about the supply of drugs online, and in particular in relation to the gaps in regulation of that industry in other PFD reports. As detailed above, I share those concerns.
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 July 30, 2024. 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], Mr Dixon's daughters • The University Hospitals of Leicester NHS Trust • Leicestershire Partnership NHS Trust

	• Long Lane Surgery 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: 04/06/2024**  **Miss I THISTLETHWAITE** **His Majesty's Assistant Coroner for Rutland and North Leicestershire**