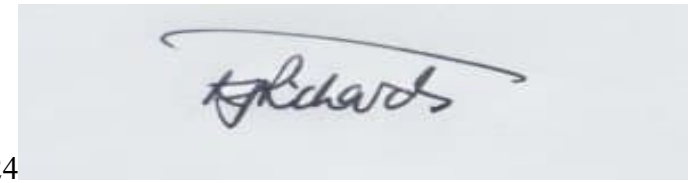
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Community Pharmacist and Director York Road Pharmacy, Peterlee.** **2. The General Pharmaceutical Council (GPhC).**
1	**CORONER** I am Janine Richards, assistant 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.
	INVESTIGATION and INQUEST On the 4th of September 2023 an investigation was commenced into the death of Anthony Paul Nixon. The investigation concluded at the end of the inquest on the 15th of August 2024 . I gave a conclusion that the death was drug related and that the actions of the Pharmacy contributed more than minimally in supplying additional [redacted] on multiple occasions, not in accordance with the prescription for such. The medical cause of death was :- 1a) The combined toxic effect of [redacted], [redacted] and [redacted].
4	**CIRCUMSTANCES OF THE DEATH** Anthony Paul Nixon, aged 45 years, was found deceased on the 12th June 2023 at his home address. He died as a result of an a drug overdose, having taken a combination of [redacted], [redacted] and [redacted], which in combination led to a fatal toxicity. Despite a prescription for supervised consumption of [redacted] on specific days, including a home office approved form of wording on the prescription in relation to such, on a number of occasions in the period leading to his death, the deceased was given his [redacted] in advance for days when the pharmacy was open, which was not in accordance with the prescription which was issued for him, which was designed to reduce the obvious risks of the deceased taking additional [redacted].

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. – (1) The Pharmacist in this case gave evidence that he believed that he had a discretion to provide [redacted] in advance, and not in accordance with the prescription for supervised provision of [redacted] on specific days, and maintained this was a "standard practice" when the Pharmacy was open for half a day on Saturdays. He interpreted the wording on the prescription namely "please dispense instalments due on a Pharmacy closed days on a prior suitable date" to include Saturdays when the Pharmacy was open for half a day, despite the prescriptions stipulating the specific days that the [redacted] was to be provided, including specification of the dose each Saturday. (2) This led to a situation where the deceased was in possession of multiple doses of a controlled drug, namely [redacted], on a regular basis in the period leading up to his death, which was not in accordance with the prescription, which had been carefully considered to attempt to manage the obvious risks of such. (3) The Pharmacy had been specifically chosen by the deceased's drug treatment provider because it was able to provide supervised administration of [redacted] on a 6 day per week basis and because in their assessment this was required to attempt to manage the risks inherent in the deceased having access to multiple doses. (4) The treatment provider were not alerted to the fact that the deceased was regularly receiving additional doses of [redacted], not in accordance with the prescription they had issued, and so was unable to risk manage the suitability of the prescribing arrangements. (5) I was not reassured that the Pharmacist fully appreciates the gravity of this situation, and that in evidence he continued to maintain that he could exercise a discretion in relation to the provision of [redacted], a controlled drug, and provide this not in accordance with specific prescription instructions on the days specified when the Pharmacy was open, and further that was described as a standard practice. (6) For the avoidance of doubt, the circumstances of this case have been alerted to the General Pharmaceutical Council, as the appropriate regulator, but there has been no update received as to whether an investigation has been undertaken or any action recommended.
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 11.10.24 . 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; the Family of the deceased and 'My space' supported housing provider. I have also sent a copy to CGL (Change Grow Live) and Humankind - drug and alcohol treatment agencies, and to the Care Quality Commission (CQC) who may find it useful or of interest. 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	 16.08.24