## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. The Chief Medical Officer VMD, The Veterinary Medicines Directorate, Veterinary Medicines Directorate, Woodham Lane, New Haw, Addlestone, Surrey, KT15 3LS**<br><br>**2. The Chief Executive Officer, Royal College of Veterinary Surgeons, Royal College of Veterinary Surgeons, 3 Waterhouse Square, 138-142 Holborn, London EC1N 2SW**<br><br>**3. The Chief Coroner for England and Wales, Chief Coroner's Office, Room C09, Royal Courts of Justice, Strand, London, WC2A 2LL** |
| 1 | **CORONER**<br><br>I am Christopher Williams an Assistant Coroner, for the Coroner Area of Inner London South (Southwark Coroners Court). |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On the 22/1/2024 an investigation commenced into the death of **Edward John Youde Barnard** born 23/3/1994 and died on 9/1/2024<br><br>The investigation concluded at the end of the inquest on 15 November 2024.<br>The medical cause of death was:<br><br>*1(a) Fatal [redacted] overdose*<br><br>*II*<br><br>My Conclusion as to the death, section 4 Record of Inquest, was *"Suicide"* |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>On the 8/1/2024 Edward checked into a hotel and on the following morning he was found deceased in his room by a staff member. The ambulance and police services attended, and it was determined that there were no suspicious circumstances. A note was found in the room from Edward to the hotel staff, which stated:<br><br>*"Please call 999 and report as suicide. I'm sorry I ruined your day."*<br><br>A postmortem examination and toxicological analysis concluded that the death was caused by a 'Fatal [redacted] overdose".<br><br>Edward had a history of anxiety and depression and had attended Cognitive Behaviour Therapy counselling in 2018 he also had a heart defect which was operated in 2021 which had a detrimental effect on his mental well-being. |

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| | I concluded that he took the [redacted], with the clear intention of ending his life, after he checked into the hotel room.<br><br>The toxicology report recorded a [redacted] blood level of [redacted] ug/ml and noted the fatal level was [redacted] ug/ml.<br><br>The toxicology report went on to state that [redacted] was a short acting barbiturate used in the UK only as an anaesthetic agent in *Veterinary Medicine*. |
| 5 | **CORONER'S CONCERNS**<br><br>From the evidence I received, at the inquest, there are 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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>On completion of the inquest, I was concerned that Edward, a vulnerable young adult, managed to come into possession of [redacted], a substance which I understand from the Toxicology report, is only licensed for use on animals by qualified veterinary professionals. I infer from the Toxicology evidence and the fact that Edward was not a veterinary professional that he must have obtained the substance from an illicit source. I am concerned that if I do not make a report a potential emerging risk to life may slip past public attention unnoticed.<br><br>I therefore make this report to the **Veterinary Medicines Directorate,** whom I understand is the organisation responsible for licensing [redacted], so that the Directorate is aware that the drug has been used for a suicidal purpose and to enable the organisation to examine any available preventive measures to reduce the risk of this suicide method occurring in future.<br><br>I am also reporting this fatal incident to the **Royal Society of Veterinary Surgeons** to share the information with its members and to ensure that those to whom the drug is licensed are made fully aware of its potential to be used in the completion of suicide by humans. I also make the report to the Royal Society to take any available preventive measures to reduce the risk of this suicide method in future. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe your organisations have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by the **16th January 2025.** I, the coroner, may extend the period on request.<br><br>Your responses 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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons who may find it useful or of interest:<br><br>- The family of Edward John Youde Barnard<br><br>I am also under a duty to send the Chief Coroner a copy of your response. |

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| | The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she 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:** **Signed:**<br><br>**21st November 2024** **Christopher Williams** |