REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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	THIS REPORT IS BEING SENT TO:
	The Home Secretary
1	CORONER
	I am Alison Mutch, Senior Coroner, for the coroner area of South Manchester
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 th June 2024 I commenced an investigation into the death of James Patrick BOLAND .The investigation concluded on the 17 th October 2024 and the conclusion was one of narrative: Died from the complications of pyelonephritis probably contributed to by the complications of chronic ketamine use. The medical cause of death was 1a) Sepsis 1b) Acute Pyelonephritis on a background of Chronic Ketamine use
4	CIRCUMSTANCES OF THE DEATH
	On 19th June 2024 James Patrick Boland known as Jamie was a chronic user of ketamine. He had developed significant urological issues as a consequence from the ketamine use. He was found unresponsive at his home address. A post mortem examination was undertaken. He was found to have a non-fatal level of ketamine in his system, but to have died from sepsis caused by acute pyelonephritis, a complication of long term use of ketamine.
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 will 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 inquest heard evidence that previously Mr Boland had used cocaine a class A drug but, had switched to ketamine a class B drug on the basis that he perceived it to be less harmful. His perception that it was less harmful was based on the fact it is designated as a class B rather than Class A drug. The evidence before the inquest was that Ketamine is a deeply harmful substance when used outside the purposes for which it is licenced for prescribing by clinicians and that users such as Mr Boland are unable to give it up despite knowing how dangerous it is to their health. Maintaining its

classification as a Class B drug was likely to encourage others to start to use it or continue to use it under the false impression it is "safer". The evidence at the inquest was that Ketamine use causes huge long term life changing health problems. In Mr Boland's case it had caused long term urological damage and liver damage. It was the damage to his urological system caused by Ketamine that led to his death. The inquest was told that there is a significant increase in the illicit use of Ketamine and that this has led to clinicians seeing a rise in potentially fatal health problems linked to its use. The extent of these risks rarely understood by users until the damage has been done to their health. **ACTION SHOULD BE TAKEN** 6 In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 31st December 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 namely on behalf of the family, 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. Alison Mutch **HM Senior Coroner**

05/11/2024