REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Clare House Surgery, Newport St, Tiverton EX16 6NJ** **2. Royal Pharmaceutical Society, 66 East Smithfield, London E1W 1AW** **3. Pharmacy2U Limited, Lumina, Park Approach, Thorpe Park, Leeds LS15 8GB**
1	**CORONER** I am Luisa Maria Nicholson, HM Assistant Coroner for Devon, Plymouth & Torbay
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 7th December 2023 an investigation into the death of Oliver James Billings aged 22 was commenced. The investigation concluded at the end of the inquest on 28th November 2024. The conclusion of the inquest was that Mr Billings' death was due to suicide. The medical cause of his death was established as 1a) Toxic effect of [redacted].
4	**CIRCUMSTANCES OF THE DEATH** Oliver was found deceased at his home address on 6th December 2023 having consumed possibly as many as 266 x 75mg tablets of his prescribed [redacted]. It appears that he had hoarded some of his medication and also appears to have acquired 112 tablets on or around 29th November 2023 due to a prescribing error where he changed his choice of chemist from an online pharmacy ('Pharmacy2U') to a local 'Superdrug' store. His Surgery, Clare House Surgery, Tiverton sent an electronic request to Pharmacy2U to cancel the prescription and then issued the second to Superdrug; however, Pharmacy2U had already "pulled down" the prescription before it was cancelled electronically. They then dispatched 112 x 75mg [redacted] to Oliver by post on 28th November. This meant that Oliver was still able to collect the second prescription for 112 x 75mg [redacted] from Superdrug and was suddenly in possession of 224 tablets. The Surgery sent Oliver a text message asking him to contact Pharmacy2U to "return the prescription to the spine" which presumably he chose to ignore. He had a long-established history of issues with his mental health including anxiety, depression, self-harm and previous suicidal ideation. He was also aware of his own impulsiveness. A note was found by a police officer attending Oliver's flat on the day he died which stated that he did not have control over his medication and would take them all if left unsupervised. This is sadly what appears to have happened.
5	**<u>CORONER'S CONCERNS</u>** 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. –

	(1) That a subsequent prescription was submitted in the knowledge that the first was cancelled or to be cancelled but that steps do not appear to have been taken or be able to be taken to ascertain the status of that prescription before the subsequent prescription was issued. (2) That the swift dispatch of medication (whilst admittedly necessary in many circumstances) does not allow for mistakes to be noticed and/or remedied. (3) That the onus was on Oliver to remedy the error when Pharmacy2U could not be contacted.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 **24th January 2025**. 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 Oliver's parents, Mr and Mrs Billings. 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. 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	***Luisa Maria Nicholson*** **HM Assistant Coroner** **28th November 2024**