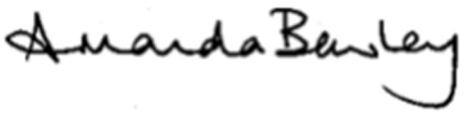
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Secretary of State for Health and Social Care** **2. The Secretary of State for the Department for Science, Innovation and Technology** **3. The Medical and Healthcare Regulatory Authority** **4. The Financial Conduct Authority** **5. The Chief Coroner**
1	**CORONER** I am Amanda Bewley, Assistant Coroner, for the coroner area of Nottingham and Nottinghamshire
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 7 March 2024, I commenced an investigation into the death of Susan Marie Karakoc. The investigation concluded at the end of the inquest on 28 November 2024. The conclusion of the inquest was a narrative conclusion: Susan Marie Karakoc sought to treat her symptoms of fibromyalgia with [redacted] and [redacted] which she obtained from websites selling prescription medication off-label. Susan had levels of [redacted] associated with fatalities and [redacted] at a potentially toxic level. Those medications taken together acted synergistically to depress Susan's cardiorespiratory system which led to her suffering hypoxic brain injury which in turn caused her to suffer multiple organ failure which led to her death.
4	**CIRCUMSTANCES OF THE DEATH** On 1 December 2023, Ms Karakoc collapsed at her home address. She was found by a family member and transported to hospital by ambulance. Investigations at hospital found Ms Karakoc had suffered a hypoxic brain injury which was not survivable. Ms Karakoc died on 2 December 2023. Following Ms Karakoc's death, toxicological examination revealed that the catalyst for the chain of events leading to Ms Karakoc's death was [redacted] and [redacted] toxicity. Ms Karakoc was not prescribed either of these medications by her General Practitioner and the General Practitioner was unaware of Ms Karakoc taking those medications.

	Ms Karakoc's family provided evidence which proved that Ms Karakoc obtained these medications from online sources via websites set up to sell prescription medication off-label. Ms Karakoc made over 100 purchases of [redacted] and [redacted] in a period of a little over a year. The ready availability of medications such as these to purchase from websites circumvents the patient safety measures in place and places vulnerable persons at risk of death. This represents a real and ongoing risk of future deaths occurring.
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 – 1. There is evidence of search engines readily returning websites which sell prescription medications, including those that sell highly addictive sleeping tablets and painkillers which can and do cause fatalities. I am concerned how readily search engines return websites such as these; 2. I am concerned that the current system for monitoring the legitimacy of supply chains for medications available in England and Wales via prescription is not preventing the ready supply of such medications online; 3. There is evidence that banks form a legitimate part of the supply chain, and that this is crucial to the functioning of these criminal enterprises. I am concerned that the current system for detecting such criminal enterprises and alerting the relevant authorities is not effective. I am not reassured that necessary actions to address the serious issue identified are in place.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe you have the power to take such action in relation to at least one of the concerns identified herein.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by the **10 February 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 following Interested Persons: - Susan Karakoc's family

	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 will send a copy of my report to the following: 1. The Secretary of State for Health and Social Care 2. The Secretary of State for the Department for Science, Innovation and Technology 3. The Medical and Healthcare Regulatory Authority 4. The Financial Conduct Authority 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. 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.



Amanda Bewley
HM Assistant Coroner
Nottingham and Nottinghamshire Coroners Service

17/12/2024