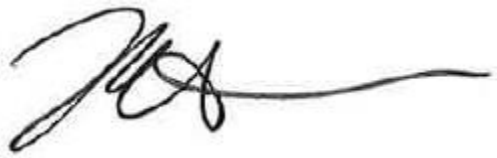
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1) Secretary of State for the Home Department** **2) Secretary of State for Health And Social Care** **3) Secretary of State for Education**
1	**CORONER** I am Brendan Joseph Allen, Area Coroner, for the Coroner Area of Dorset
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 the 27th January 2025, an investigation was commenced into the death of Gemma May Weeks, born on the 13th November 1996. The investigation concluded at the end of the Inquest on the 6th August 2025. The Medical Cause of Death was: 1a Combined drug toxicity (ketamine and [redacted]) 1b 1c 2 Urinary bladder necrosis and chronic pyelonephritis due to ketamine The conclusion of the Inquest recorded that Gemma May Weeks' death was drug related.
4	**CIRCUMSTANCES OF THE DEATH** Miss Weeks had been a ketamine user for approximately 10 years. Her use of ketamine, a controlled drug of class B, had increased over the years and there are reports that in 2024 she was using approximately £500 of ketamine per

	week. Long term use of ketamine had had a detrimental effect on Miss Weeks' health. She was significantly underweight (ketamine suppresses the appetite) and had developed ketamine bladder syndrome, a condition associated with considerable pain and incontinence. Despite the health complications caused by the regular ketamine use, Miss Weeks was unable, even with considerable support, to achieve a sustained period of abstinence. She reported that the pain caused by the damage to her bladder could only be relieved by the analgesic properties of ketamine, thereby leading to further and increased use, causing further bladder damage. On 26th January 2025 she was found deceased in her room at her temporary accommodation. She had consumed high levels of ketamine and [redacted], the combined effects of which caused her death.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: 1. During the inquest evidence was heard that: i. Ketamine is a controlled drug of class B. There is a perception in naïve users that this signifies "lesser" risks associated with using ketamine as compared with class A drugs. However, in acute overdose, ketamine can be fatal. It is also highly addictive, with reports of usage notably increasing in young people, among whom the risks of ketamine use do not appear to be well understood. I heard evidence that ketamine has become easily, widely and cheaply available. Local drug treatment agencies have seen a corresponding increase in individuals reporting ketamine addiction and seeking assistance for the same. In addition, chronic ketamine use can lead to devastating health complications, including ketamine bladder syndrome, an extremely painful condition that requires reconstructive surgery to repair. 2. I have concerns with regard to the following:

	i. The dangers and risk associated with both acute and chronic ketamine use are not well understood by the public and potential first time users of the drug. Ketamine's classification as a class B controlled drug may give an impression that the dangers associated with its use are reduced as compared with class A drugs. ii. There is little understanding of the risks and dangers of ketamine use amongst the age group that appear to be at most risk of starting to use the drug. iii. The health consequences of chronic ketamine use are well understood by those that encounter them, including drug treatment providers and those working in healthcare. Those consequences are not, however, well understood outside of those circles.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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, by 14th October 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 the following Interested Persons: (1) [redacted] (Miss Weeks' mother) (2) [redacted] (Miss Weeks' sister) (3) [redacted] (Miss Weeks' sister) (4) [redacted] (Miss Weeks' sister) (5) [redacted] (Miss Weeks' father) (6) Dorset Healthcare NHS Foundation Trust 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	**Dated** 19th August 2025	**Signed**  **Brendan J Allen**