H.M. Senior Coroner, South London Area

South London Coroner's Office
Saint Blaise Building, Bromley Civic Centre
Stockwell Close, Bromley BR1 3HU
Telephone 020-8313 1883 Fax 020-8313 3673

Coroners and Justice Act 2009; section 32; schedule 5, paragraph 7
The Coroners (Investigations) Regulations 2013 Regulation 28:

REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: 1. **Chief Executive, Bromley Drug and Alcohol Service** 2. **Supervising Pharmacist, United Pharmacy, Croydon**
1	**CORONER** I am senior coroner for the coroner area of South London
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. Statutory Instrument 2013 no.1629
3	**INVESTIGATION and INQUEST** On 8th January 2013 I commenced an investigation into the death of Deanne Naomi Smith, born on 29 May 1978 and who died on 8th January 2013. The investigation concluded at the end of the inquest on 28th March 2014.
4	**CIRCUMSTANCES OF THE DEATH** Deanne Smith was dependent on drugs. Because of concern about the high dosage of medication she requested from her general practitioner, the GP referred her to the local Drug and Alcohol Dependency Unit. Deanne was assessed by Bromley Drug and Alcohol Service, first on 23 February 2012 and again on 18 December 2012. Her treatment plan included supervised consumption of 70mg of methadone daily which was to be changed to daily unsupervised consumption after three consecutive drug-free urine samples. On 18 December 2012 Deanne reported that she had relapsed and had been using £40-£60 heroin a day. The treatment plan following this appointment was to commence on 30mls methadone which was to be increased gradually to 50mls in line with titration guidelines. Deanne was to be reviewed in 3 months time but died on 8th January

	2013. Deanne's sister visited on 8th January 2013 but was unable to gain entry so called emergency services. Deanne was pronounced dead at 09.50h. Police officers who attended the scene found "*approximately 9 x 50mls methadone bottles in the room, about 7 of which were empty and 2 were full. ... 6 bottles were prescribed to Deanne on 24.12.2012 and another 6 on 31.12.2012 these had been collected from United Pharmacy.*"
5	**CORONER'S CONCERNS** The evidence I heard at the inquest concerns me in that at times of public holidays, such as Christmas and New Year, when the usual pharmacy is closed for some of the days, an appreciable quantity of methadone is dispensed and provided for the individual to use on days over the holiday period. When the individual is dependent on opiates and is known to acquire opiates both legally and illegally, it seems appropriate to question to wisdom of providing several days' supply at one time. I invite the Drug and Alcohol Service and the Pharmacy to reconsider their policies and procedures for the provision of methadone to drug-dependent individuals at times of public holiday when the usual methods of provision are suspended. If drug-dependent individuals are permitted to take away several days' supply in one visit, there must remain a risk of future deaths. Part of a coroner's duty at an inquest is to make a report such as this, intended to assist in the prevention of future deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you or your organisation has 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. I, the coroner, may extend the period if requested to do so. 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 mother of Deanne Smith and to Deanne's general practitioner [redacted] of the Park Practice and to the Chief Executive of Oxleas NHS Foundation Trust (Bracton Centre). 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	DR R N PALMER, H.M. CORONER SOUTHERN JURISDICTION OF GREATER LONDON ST BLAISE BUILDING BROMLEY CIVIC CENTRE STOCKWELL CLOSE BROMLEY BR1 3UH **31st March 2014** **[SIGNED BY SENIOR CORONER]**