	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Crispin Blunt Esq MP** **Parliamentary Under Secretary of State** **Ministry of Justice** **102 Petty France** **London** **SW1H 9AJ**
1	**CORONER** I am Stuart P G Fisher, Senior Coroner, for the Coroner area of Central Lincolnshire
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 29/4/13 I commenced an investigation into the death of Hazel Claire Polkinghorn (33 years), The conclusion of the inquest on 17/2/14 was a Narrative Conclusion.
4	**CIRCUMSTANCES OF THE DEATH** Hazel Polkinghorn had a history of mental health difficulties extending back to her teenage years. In 2012 she was diagnosed with Emotionally Unstable Personality disorder (borderline) and Hypochondriacal Disorder. She had recently been admitted (on a voluntary basis) to a local Psychiatric Hospital between the 8th July 2012 and 10th November 2012. On the 21st November 2012 Miss Polkinghorn was transferred to Discovery House (a Psychiatric Rehabilitation Unit) once again based in Lincoln. Whilst at Discovery House she received Psychological treatment. On or about 9th April 2013 Miss Polkinghorn was discharged from Discovery House into the Community; she took up residency in a flat. A package of support had been agreed at her discharge meeting on 9th April 2013. It was established at the inquest that Miss Polkinghorn had acquired non-prescribed medication from the internet for a period of some 4 to 4 ½ years prior to her death. It was further established that on or about 25th March 2013, Miss Polkinghorn obtained further non prescribed medication from the internet which appears to have been despatched from Mexico. On the 24th April 2013 Miss Polkinghorn was found deceased in her flat having taken an overdose of Pentobarbital. Miss Polkinghorn left notes intimating that she intended to take her own life.
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. – Miss Polkinghorn acquired non prescribed medication from the internet. She took an overdose of the drugs so acquired and died on the 24th April 2013. I am deeply concerned regarding the ease with which Miss Polkinghorn managed to acquire Pentobarbital (and other medication) from the internet. I am particularly concerned that other similar deaths will occur unless steps are taken by Central Government to screen and close down websites such as this which are engaged in selling potentially dangerous non prescribed medication.

6	**ACTION SHOULD BE TAKEN** In my opinion 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, namely by 23rd April 2014. 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 [redacted] and Lincolnshire Partnership 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	**[DATE]** 26th February 2014 **[SIGNED BY CORONER]**