ANNEX A

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:** **The Rt. Hon. Norman Baker MP** **Minister of State for Crime Prevention** **Home Office** **Marsham Street** **London SW1P 4DF**
1	**CORONER** I am David Clark Horsley, senior coroner for the coroner area of Portsmouth and South East Hampshire.
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 8th July 2013 I commenced an investigation into the death of Matthew Alexander Flatman, age 35. The investigation concluded at the end of the inquest on 2nd September 2014. The conclusion of the inquest was: Narrative Conclusion: 1- Matthew Alexander FLATMAN died at Queen Alexandra Hospital, Portsmouth, at 08.50 hours on 5th July 2013 having been taken there by ambulance having experience chest, jaw and arm pain at around 07.00 hours and a cardiac arrest at 08.00 that day. 2- The previous evening he had taken a "legal high" substance, MDAI. 3- Although his post-mortem examination revealed that he had died from a myocardial infarction and that he had severe coronary artery disease, on the balance of probabilities, his consumption of MDAI precipitated the myocardial infarction and his subsequent cardiac arrest.
4	**CIRCUMSTANCES OF THE DEATH** Matthew Alexander FLATMAN died at Queen Alexandra Hospital, Portsmouth, at 08.50 hours on 5th July 2013 having been taken there by ambulance having experience chest, jaw and arm pain at around 07.00 hours and a cardiac arrest at 08.00 that day.
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) The "legal high" taken by Matthew Flatman was a substance known as Gogaine or MDAI. This substance is in the process of being proscribed as an illegal drug but the process is moving very slowly. (2) MDAI presents a fatal risk to all its users but particularly to those with cardiac problems and its proscription should be accelerated.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 1st December 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] (Matthew's wife) - [redacted] (Matthew's father) 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	**6th October 2014** **[SIGNED BY CORONER]** **David Clark Horsley**