REGULATION 28: REPORT TO PREVENT FUTURE DEATHS.

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THIS REPORT IS BEING SENT TO:

Rt Hon Jeremy Hunt MP, Secretary of State for Health

1 CORONER

I am Fiona Borrill, H.M. Area Coroner for the area of Manchester City.

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 INQUEST

On 9th September 2015 I commenced an investigation into the death of Elvis Terrence Gene Snelson, aged 29 years. The investigation concluded at the end of the inquest on 21st January 2016.

The cause of death was found to be:

1a Acetylfentanyl toxicity

The conclusion of the inquest was drug related death.

4 CIRCUMSTANCES OF THE DEATH

On 27th August 2015, Mr Snelson was found unconscious in Room 23 at Le Ville Hotel in Manchester at about 11.10am by a member of hotel staff. Paramedics attended and cardiopulmonary resuscitation was carried out. He was taken to Manchester Royal Infirmary by ambulance, but despite further resuscitation, death was confirmed at 12.35pm on 27th August 2015.

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:

During the course of the inquest, I heard evidence from as to the medical cause of Mr Snelson's death. She had provided a post mortem report and histopathology report, which incorporated toxicology findings. The evidence I heard confirmed that acetylfentanyl is a 'designer drug' and is described as a 'legal high'. It is an opioid analgesic and I heard evidence that it reported as being 5-15 times more potent than heroin and 80 times more potent than morphine. I understand that it has never been licensed for medical use and has only been sold illegally, but as a 'legal high'.

It appears to me that although the number of fatalities arising as a result of acetylfentanyl toxicity are low, the toxic effects of this drug being sedation and respiratory depression will be a particular problem if the user is unaware that they have purchased/used an opioid drug.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

- To publicise more widely the potential toxic effects of this drug, which can lead to fatalities
- To circulate updated information with regard to this drug within the NHS and via the Coroners' Society

Additionally, I would be grateful if you would inform me as to the number of fatalities the Department of Health is aware of having occurred as a result of acetylfentanyl toxicity from 2014 to date.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 8th April 2016. 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 Interested Persons.

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}**

{NAME OF CORONER}