DAVID RIDLEY
Senior Coroner for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Dr Ian Hudson, Chief Executive Medicine and Health Care Product Regulatory Agency, 151 Buckingham Palace Road, London, SW1W 9SZ** 2. **Rt. Hon. Theresa May MP, Home Secretary and Member of Parliament for Maidenhead, House of Commons, London, SW1A 0AA**
1	**CORONER** I am David Ridley, HM Senior Coroner for Wiltshire and Swindon
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 09 September 2015 I commenced an investigation into the death of Daniel James Paylor aged 39. His Inquest was opened on the 16th November 2015 following the receipt from the Pathologist of a cause of death being attributable to opiate overdose. I concluded the investigation at a final Inquest hearing on Wednesday 29th June 2016. The conclusion of the Inquest was that Daniel, known to his family as Dan, had died as a result of an opiate overdose. My formal conclusion on the Record of Inquest as to his death was "Misadventure". I was not satisfied to either of the two standards of proof that Dan intended to take his own life.
4	**CIRCUMSTANCES OF THE DEATH** Dan had for a number of years been employed as a Paramedic with the South Western Ambulance Service. He was registered as a Paramedic with the Health & Care Professions Council ("HCPA"). He had been diagnosed with Bi-polar disorder back in 2010 and had suffered with intermittent depression predominately since 2006. He had first sought help insofar as an addiction to Codeine it appears following an accidental overdose in August 2014. That resulted in a referral to the Mental Health professionals but he was discharged from their care in February 2015. It appears that he relapsed insofar as his addiction to Codeine in July 2015 at which stage he sought advice from a drugs advisory body called Turning Point. They offered to provide support and assistance to Dan on the basis that he had to disclose to his employer that he had an addiction to Codeine. He made this disclosure in August 2015 but as his duties would not involve him coming into contact with opiate based drugs he was

	allowed to continue work with their support and the knowledge that he was in receipt of help from Turning Point. No disclosure was made to the HCPA. At Inquest it appears that despite a positive obligation on an employee to disclose secondary work to his employer (South Western Ambulance Service) Dan had never disclosed that for a number of years he had been providing paramedic services privately to local motor cross events. It appears that his registration as a paramedic enabled him to privately acquire and store in a safe a variety of drugs including morphine based drugs such as Oramorph. I heard evidence from [redacted] one of his work colleagues and a good friend, that the list of available drugs that can be acquired in this way is prescribed by the Medicine and Health Care Products Regulatory Agency and that the control of those drugs in terms of their keeping is overseen by the Home Office. Whilst guidance is given as regards the keeping of the drugs, health care professionals it appears have to devise their own paperwork to all intents and purposes to record the administering of drugs from time to time and the replacement of drugs that have gone, say, past their use by date. I was told by [redacted] that the Home Office have a power to make random checks but he himself has not been subject to one having been actively involved in these events for some 7 years. Having heard the evidence I found that more likely than not at the end of a shift on the morning of the 1st September 2015 Dan returned to his brother's home where he was staying and at some point after that opened the safe more likely than not at a time of relapse and consumed a 100ml bottle of Oramorph. His unresponsive body was discovered by his brother lying on the bed on the afternoon of the 2nd September 2015 and the post mortem examination revealed that Dan had died from an opiate overdose (1303 micrograms per litre of blood free morphine).
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows (1) I am concerned when comparing the regulation and control of drugs, say, within an hospital and in Dan's case insofar as his primary employer is concerned, an ambulance service, that compared to the level of control in relation to his secondary employment that the degree of regulatory control including safeguards and auditing appear to be very much dependent on trust. There appears to be little requirement for peer supervision and say double authorisation for say unlocking a safe comprising of two locks. My experience in relation to local hospitals is that in relation to drugs cabinets procedures have developed that require more than 1 health care professional's authority to remove drugs to administer them to a patient. There have been instances whereby health care professionals within hospitals have had addictions to prescription drugs however at least in that environment there is a stiff regime for supervision which appears absent in the scenario outlined above. I fully accept that even with regulation unless it includes the use of double locked safes with separate key holders that even with the most rigorous regulation that Dan's death may not have been avoided. I was satisfied on a balance of probabilities that he consumed the whole bottle of Oramorph within that 36 hour period prior to his death. I am, however, of the view that consideration ought to be given as regards improving the regulatory regime and control with a view to the prevention of future deaths in perhaps a slightly different scenario.
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 to address the concern highlighted above.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 25 August 2016. I, the Senior 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] (wife of Dan) and South Western Ambulance Service (for information). 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 Assistant Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	Dated 1st July 2016 Signature  HM Senior Coroner for Wiltshire and Swindon