REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Home Office, London 2. Department of Health, London
1	**CORONER** I am Ms L Hashmi, HM Area Coroner for the Coroner area of Manchester North.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 12th December 2016 I commenced an investigation into the death of **Jane Allison Powell.** My investigation was concluded by way of an inquest hearing that commenced on the 20th October 2017, concluding on the 27th October 2017.
4	**CIRCUMSTANCES OF DEATH:** Ms Powell was a qualified Pharmacist by profession although at the time of her death she was no longer licensed to practise. Against a backdrop of enduring mental illness (more likely than not due to a borderline emotionally unstable personality disorder and insecure attachment, rather than the historic diagnosis of bi-polar affective disorder), a concern for the deceased's welfare was raised by a neighbour on the 6th December 2016. Police attended her home address and forced entry whereupon she was found deceased in the living room area of the property. The deceased had last been seen alive between the 25th and 28th November 2016. A linear mark to the deceased's neck was noted. A forensic post mortem was conducted and a fracture to the larynx identified. Both the mark and the fracture were in keeping with a recent attempt to self-ligature but were not causative of death. Toxicological analysis identified both prescribed and over the counter medication, almost all of which potentially carried sedative effect. Furthermore, the deceased had been purchasing large amounts of additional medication over the internet. Despite post-mortem changes and having taken into consideration post mortem redistribution, the thrust of the evidence supported a finding of multiple drug toxicity as the probable cause of death. There was insufficient evidence to conclude, to the required legal standard, that the deceased had 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:- 1. The evidence in this case demonstrated how easy it is for individuals to obtain large amounts of medication (including those normally deemed to be 'prescription only' drugs) over the internet. Whilst this problem has already been recognised by the pharmaceutical profession and its regulatory body, it is unclear what action has been/is being taken in order to address the situation. My concern is that, if left, there is a significant risk of future deaths.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 the 27th December 2017. 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 namely:- - The deceased's family - Pennine Care NHS Foundation Trust - Oldham Metropolitan Borough Council - General Pharmaceutical Council 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 from. 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: 30th October 2017 Signed: