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:** **1. Secretary of State For Health** **2.** **3.**
1	**CORONER** I am Geraint Urias Williams, Senior Coroner, for the coroner area of Worcestershire
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 16th February 2017 I commenced an investigation into the death of Bethany Victory SHIPSEY then aged 21 The investigation concluded at the end of the inquest on 14th February 2018. The conclusion of the inquest was narrative (attached), the medical cause of death being Dinitrophenol poisoning
4	**CIRCUMSTANCES OF THE DEATH** Bethany Shipsey was a young woman with significant mental health difficulties who, on 15 February 2017, died as the result of suicide having deliberately ingested a quantity of tablets containing the drug Dinitrophenol which she had purchased over the Internet. She did so intending to take her own life and was admitted into the Worcestershire Royal Hospital at approximately 5:30 PM on that day. The clinicians having care of her recognised the extreme toxicity of the drug, the lack of antidote, the risk of rapid deterioration and the need for close monitoring of her condition with a view to providing supportive treatment. Notwithstanding this the clinicians failed to take sufficient or adequate steps to monitor her leaving them unprepared to deal with the rapid deterioration which ensued. There were significant failings in the care given to her which amounted to a lost opportunity to provide supportive treatment which although probably would not have saved or prolonged her life may nevertheless have done so.
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 inquest heard evidence from Prof Simon Thomas, the national clinical lead for Toxbase and an acknowledged expert in dintrophenol toxicity. His unchallenged evidence was that DNP is extremely toxic, with no known antidote and that it is becoming increasingly popular with young people as a "diet pill" and is freely available via the Internet. [redacted] gave evidence to the effect that this drug is likely to cause further fatalities and urged that steps are taken to make it illegal to possess, sell or supply the drug. Given the tragic death of Ms Shipsey in the circumstances outlined above I invite the Secretary of State for Health to consider introducing legislation to make illegal the possession and supply of DNP. (2) (3)
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 12th April 2018 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] Chief Executive Worcestershire Acute Hospitals Trust, Chief Executive Worcestershire Health and Care NHS 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	**Signed** ..... **G U Williams** **H M Senior Coroner** **15th day of February 2018**