

# Her Majesty's Coroner for the County of Devon

Plymouth, Torbay and South Devon Area

#### **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**

#### THIS REPORT IS BEING SENT TO:

1. Devon Local Medical Committee

**Deer Park Business Centre** 

Haldon Hill

Kennford

Exeter EX6 7XX

2. NHS Northern Eastern and Western Devon Clinical Commissioning Group

**Newcourt House** 

**Old Rydon Lane** 

Exeter EX2 7JU

#### 1 CORONER

I am Stephen Covell, Assistant Coroner for Plymouth Torbay and South Devon

# 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

David Lee Gomer TRAVERS died on 27 October 2017.

An inquest was opened on 23 January 2018.

The inquest was concluded on 24 May 2018 with a conclusion of: Drug Related Death

#### 4 CIRCUMSTANCES OF THE DEATH

Mr Travers was found unresponsive and subsequently declared deceased on 27 October 2017 During the day prior to his death he had taken a combination of illicit and prescription drugs and alcohol. At some time during the morning of 27 October he obtained and consumed a quantity of heroin.

# 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. -

Evidence from several witnesses indicated that Mr Travers was able to access multiple prescriptions for drugs by moving around Plymouth and the surrounding area and presenting to different GP surgeries as requiring drugs.

Evidence also indicated that Mr Travers would sell or barter prescription drugs to obtain illicit drugs.

There are apparently measures in place to raise alerts across GP surgeries and NHS Trusts to exchange information about persons who may be attempting to exploit the issuing of drug prescriptions, however given the above evidence, I am concerned that it is nevertheless still too easy for persons to access multiple prescriptions. This presents a risk to those who are able to obtain and take excessive amounts of prescription drugs and a route by which prescription drugs can enter an illegal drugs market **ACTION SHOULD BE TAKEN** 6 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 Friday 17 August 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. **COPIES and PUBLICATION** 8 I have sent a copy of my report to the Chief Coroner and to father of the deceased. 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. Dated: 22 June 2018 9 Signature Assistant Coroner for Plymouth, Torbay and South Devon