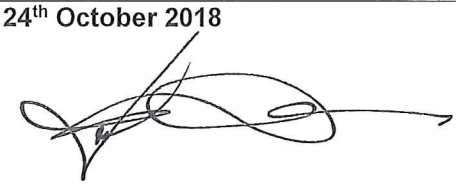
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Professor Stephen Powis, National Medical Director, NHS England, Skipton House, 80, London Road, London. SE1 6LH. [redacted] General Pharmaceutical Council, 25 Canada Square, Canary Wharf, London. E14 5LQ [redacted] Bachmačské náměstí 334 160 00 Prague 6 – Dejvice Czech Republic
1	**CORONER** I am Dr Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West London
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 the 1st September 2018, evidence was heard touching the death of **Jennifer Anne Lacey.** Ms Lacey had been found deceased in Room 122 of the Travelodge Hotel in Morden on the 4th June 2018. She was 51 years old at the time of her death. The findings of the court were as follows: **Medical Cause of Death** 1 (a) Cardiorespiratory failure (b) Tramadol and alcohol poisoning. **How, when and where the deceased came by her death:** Jenny struggled with alcohol dependence from her teenage years. She also reported feelings of suicidality. On 4/6/2018 she was discovered deceased in a hotel room.

	She had consumed a large amount of alcohol and 210 tables of tramadol, half of which at least she had obtained over the internet. **Conclusion of the Coroner as to the death:** Suicide
4	**Circumstances of the Death.** Evidence taken at the inquest confirmed that Jenny had obtained 100 tablets of tramadol 50 mg via a prescription issued by a doctor registered in Prague, who had never seen her and had no access to her medical records, nor had communicated with her GP. She had simply consulted with him over the internet and filled in an online questionnaire. It was not clear how she had obtained the other tablets.
5	**Concerns of the Coroner:** 1. That such potentially dangerous and addictive drugs are so freely available over the internet. 2. That they can be prescribed without any contact with the patient's regular medical practitioner or access to the patient's medical records. 3. That such prescriptions of such potentially dangerous and addictive drugs may be being filled in UK pharmacies without any further checks.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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] [redacted] 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	**24th October 2018**  **Dr Fiona J Wilcox** **HM Senior Coroner** **Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED**