REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) Medicines and Healthcare Products Regulatory Agency** **(2) 1st For Health International Limited** **(3) StockXS Limited**
1	**CORONER** I am Jacqueline Devonish, Area Coroner, for the coroner area of Suffolk.
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 4 December 2019 I commenced an investigation into the death of Gemma Louise Macdonald aged 22 who died on 22 July 2019. The investigation concluded at the end of the inquest on 5 December 2019. The medical cause of death was found to be: 1a. Multiorgan failure 1b. Mixed drug overdose 2 Depression The conclusion of the inquest was that Gemma died following a massive overdose of medication some of which was purchased online and taken at home on 21 July 2019. It was clear from the evidence that she did not intend the overdose to be fatal but rather it was more likely she had been responding to voices, the balance of her mind being disturbed.
4	**CIRCUMSTANCES OF THE DEATH** Gemma had been known to the mental health service since 2011 following a drug overdose. She was being prescribed medication to help her to sleep and to manage her anxiety and depression, namely Sertraline, Zopiclone and Amitriptyline, which was restricted to weekly prescriptions. On 1 July she made a purchase of 20 packs of 16 Aspirin 300mg online from 1st For Health International Limited (1st For Health). On 18 July she made an identical purchase, again from !st For Health. On 1 July 2019 she also purchased 4 packs of 20 Nurofen 400mg from StockXS Limited. Gemma told the paramedics and later the hospital clinicians that she had ingested: 400 Aspirin 300mg 80 Neurofen 400mg 7 Zopiclone 7.5mg 10 Loperamide 2mg 14 Morphine 10mg 70 Sertraline 100mg 35 Amitriptyline 10mg 56 phenoxymethylpenicillin 250mg

	Gemma ingested all 693 tablets within 30 minutes and vomited twice, once with tablets evident. The tablets were taken between 8-9pm on 21 July. She died from an overdose on 22 July 2019.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you; the **MATTERS OF CONCERN** as follows:- (1) The availability of large quantities of medication to purchase on online by an individual; (2) Whether there is a system for establishing the suitability of the purchaser; (3) Whether there is verification process enabling the limiting of transactions to the amount of medication and frequency of ordering
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you or your organisation 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 7 February 2020. I, the Area Coroner, may extend the period if I consider it reasonable to do so. 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] and West Suffolk Hospital. I am 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 Area Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**5 December 2019** Jacqueline Devonish