ANNEX A

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:** **Professor Stephen Powis National Medical Director NHS England**
1	**CORONER** I am Caroline Beasley-Murray, senior coroner, for the coroner area of Essex
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 3 January 2020 I commenced an investigation into the death of Joseph James Gingell. The investigation concluded at the end of the inquest on 3 January 2019. The conclusion of the inquest was that Joseph James Gingell killed himself.
4	**CIRCUMSTANCES OF THE DEATH** Joseph James Gingell had suffered from mental illness for a long time and he was well known to Mental Health services in Avon and Somerset. He had a fascination with the Dartford Crossing and he had travelled there at the time of his birthday. He was found deceased in a Premier Inn hotel nearby. The cause of death was mixed drug toxicity with alcohol. It became clear that the deceased had been obtaining drugs without prescription online. He was known to have a history of opioid and benzodiazepine dependence.
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 drugs found in Mr Gingell's system are known to have toxic effects when taken in excessive amounts in conjunction with other medication. (2) Permitting the patient to "self certify" without any checks can allow abuse of the system by those most vulnerable who have addiction problems. (3) Permitting the patient the option of not having a GP informed removes an otherwise effective safeguard.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 2nd April 2020. 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 – Avon and Wiltshire Mental Health Partnership [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	**17 February 2020** **Caroline Beasley-Murray**