Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 **Secretary of State for Health and Social Care**
2 **General Pharmaceutical Council**
3 **Chief Executive of the National Health Service**
4 **Chief Executive of the General Medical Council**
5 **Chief Executive of the Care and Quality Commission**

1 CORONER

I am Mrs D HOCKING, Her Majesty's Assistant Coroner for the area of Leicester City and South Leicestershire.

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 Sixteenth October 2018 I commenced an investigation into the death of Jamie Francis O'Connor aged 28. The investigation concluded at the end of the inquest on Twentieth October 2021. The conclusion of the inquest was:

Drug Related Death

The cause of death was established as:

I a [redacted] toxicity

I b

I c

II

4 CIRCUMSTANCES OF THE DEATH

Jamie O'Connor was found deceased in a sitting position in the garden of his home address in Bath Street, Leicester on the 14 October 2018 by his mother following concerns that he was not responding to her phone calls. He had a history of mental and physical illness for which he was given appropriate prescribed medication by this psychiatrist and general practitioner respectively. As there was no requirement to do so and Jamie specifically did not give permission for information sharing, neither of the clinicians were aware that Jamie was also

accessing excessive [redacted].

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows: (brief summary of matters of concern)

1. There is no central tracking system or central database to record what each person has been prescribed and dispensed and by whom. This is open to abuse as the person requesting the drugs has potential access to multiple online pharmacies who have no knowledge of what each other have been prescribing thus risking contra-indicated drugs being dispensed or over prescribing of drugs.
2. There is no requirement to contact the GP of the person requesting drugs to let them know what has been prescribed. If the person requesting the drugs chose not to share with the GP there were no red flags which might indicate further enquiries should be made with that person as to why they did not want to share with the GP.
3. There was no necessity for a face to face consultation with the person requesting the drugs and the prescriber before drugs were dispensed;
4. There was a very limited questionnaire about the history of the person requesting the drugs. If the answer was 'no' to one question which meant that the drugs could not be prescribed it was very easy to go back and alter it to 'yes' (or vice versa) if that meant that the drugs could be dispensed;
5. Persons requesting the drugs were able to ask specifically for which drug they wanted before contact with the prescriber;
6. By virtue of where the company prescribing the drugs was registered there was limited regulation.

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.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 16 December 2021. 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] (representative of the family)
[redacted] (representative for General Pharmaceutical Council)
[redacted] (representative for UK Meds Direct)
Dr [redacted] (Care Quality Commission)
[redacted] (representative of Leicestershire Partnership NHS Trust).
I have also sent it to Dr [redacted] of the Johnson Medical Practice who may find it useful or of interest.

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

Mrs D Hocking
Her Majesty's Assistant Coroner
Leicester City and South Leicestershire

Dated: 21 October 2021