	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Secretariat of the Advisory Council on the Misuse of Drugs C/O The Home Office Acmd@homeoffice.gov.uk
1	**CORONER** I am Crispin A Oliver, Assistant Coroner, for the coroner area of County Durham and Darlington.
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 19th March 2020 I commenced an investigation into the death of Claire Richards, 39 years old. The investigation concluded at the end of the inquest on 20th November 2020. The conclusion of the inquest was that Claire Richards died from 1a) Toxic Effects of Pregabalin and Buprenorphine and the conclusion was that it was a Drug Related Death.
4	**CIRCUMSTANCES OF THE DEATH** Claire Richards had a history of drugs misuse and mental health issues. She was pronounced dead at home. She had been snorting illegally dealt pregabalin and buprenorphine in the days before her death. She became very unwell, then unresponsive. Eventually those she was with summoned the emergency services, but she could not be saved and died at home. She did not intend her own death.
	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. This is notwithstanding that the concern is one concerning something which is endemic, and this case simply provides a paradigm example. I have previously sent a report in this case to the Chief Executive of the Royal Pharmaceutical Society who has replied suggesting that I send it to you. It is my statutory duty to report to you. The **MATTER OF CONCERN** is as follows. – (1) This case involves a death resulting from illegally dealt prescription drugs. It is of increasing concern that prescription drugs are available in vast quantities for illegal dealing to vulnerable people. (2) What steps are projected, or are actually in the pipe line, for stemming the leakage of prescription medication out of the lawful dispensing process into criminal hands?
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 29th April 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 Next of Kin of [redacted], who is an Interested person in the Inquest. 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	**Dated: 26th February 2021** **Signed:**  **CRISPIN A OLIVER** **HM SENIOR ASSISTANT CORONER** **COUNTY DURHAM AND DARLINGTON**