REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Chief Executive of Tameside and Glossop Clinical Commissioning Group (CCG).
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner area of South Manchester.
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 9th April 2018 I commenced an investigation into the death of Karen Moran. The investigation concluded on 4th October 2018 and the conclusion was one of **Accidental Death**. The medical cause of death was **1a) Combined effects of dihydrocodeine, gabapentin, diphenhydramine and chlordiazepoxide.**
4	Karen Moran had memory difficulties and long-standing pain for which she was prescribed medication. On 7th April 2018, she was found at her home address and taken to Tameside General Hospital where resuscitation attempts were unsuccessful. Toxicology showed raised levels of dihydrocodeine and gabapentin (prescribed

	medications). There were no suspicious circumstances or third party involvement.
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. – The inquest heard that: She had a long term addiction to prescribed medication that had been recognised. Medication continued to be prescribed on repeat prescriptions with no referral to address the addiction. The prescribing pattern meant she had access to significant amounts of prescribed medication.
6	ACTION SHOULD BE TAKEN In my opinion, action should be taken to prevent future deaths and I believe you 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 17th January 2019. 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 namely, [redacted] he deceased's mother, 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	**Alison Mutch OBE** **HM Senior Coroner** **22.11.2018**