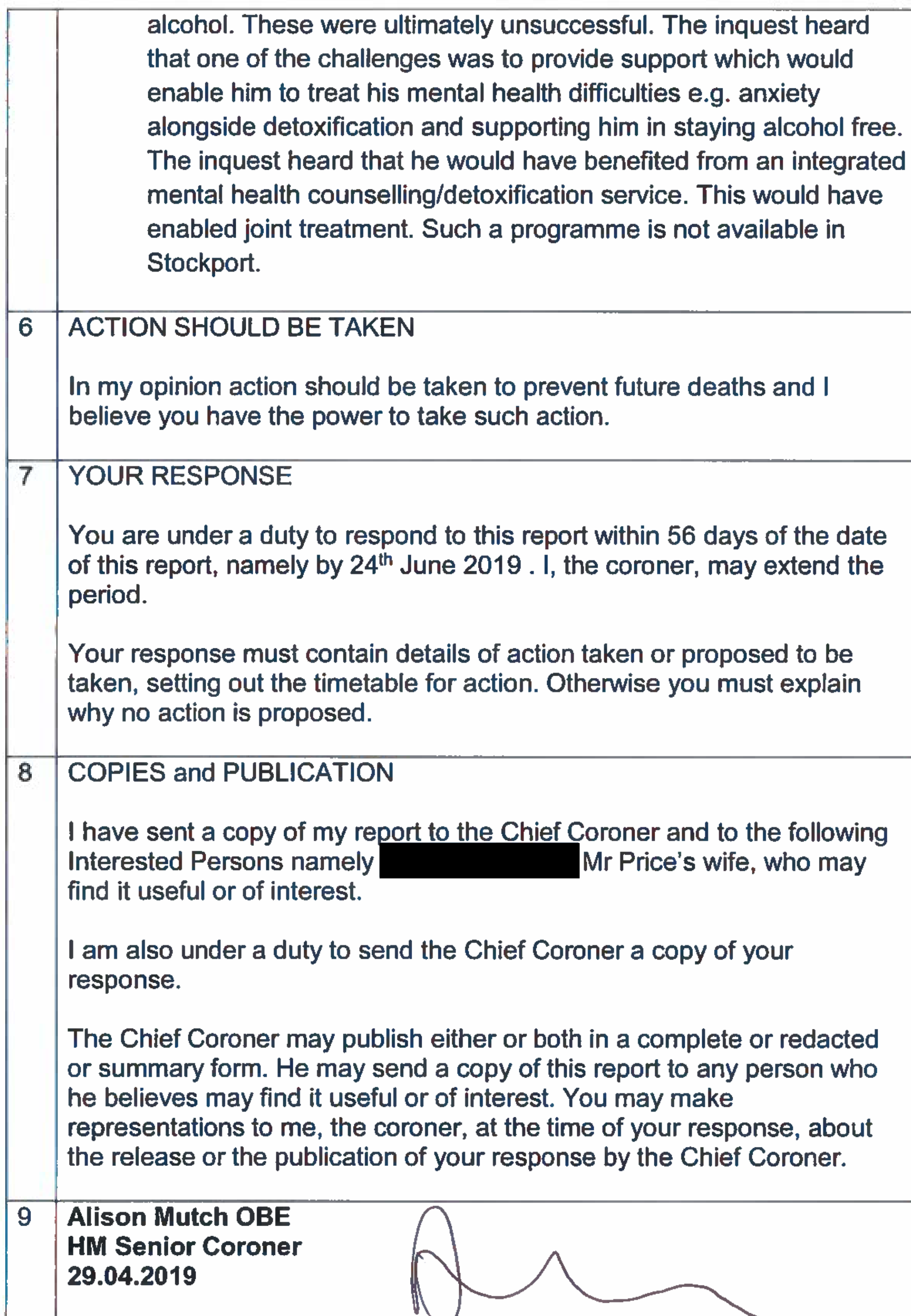
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Chief Executive of Stockport Clinical Commissioning Group
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 13th November 2018, I commenced an investigation into the death of David Alan Price The investigation concluded on the 24th April 2019 and the conclusion was one of **Alcohol-Related Death**.
4	CIRCUMSTANCES OF THE DEATH David Alan Price had a long history of using alcohol to cope with his mental health. He had successfully completed detoxification programmes in the past with subsequent relapses. He had accessed mental health services but with limited success. On 12th November 2018 he was found at his home address, [REDACTED] Post-mortem toxicology found a fatal blood alcohol reading of 509 mg%. There were no suspicious circumstances or third party involvement in his death.
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 evidence that David Alan Price had a long standing problem with alcohol which he used to self-medicate his anxiety in particular. He made a number of attempts to give up



	alcohol. These were ultimately unsuccessful. The inquest heard that one of the challenges was to provide support which would enable him to treat his mental health difficulties e.g. anxiety alongside detoxification and supporting him in staying alcohol free. The inquest heard that he would have benefited from an integrated mental health counselling/detoxification service. This would have enabled joint treatment. Such a programme is not available in Stockport.
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 24th June 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] Mr Price's wife, 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** **29.04.2019**