	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Mr Simon Stevens** **Chief Executive NHS England** **PO Box 16738** **Redditch** **B97 9PT**
1	**CORONER** I am Andrew Barkley Senior Coroner for **Stoke-on-Trent & North Staffordshire**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 24th September 2018 I commenced an investigation into the death of Andrew Peter McCall. The investigation concluded at the end of the inquest on 27th June 2019. The conclusion of the inquest was that the death was drug related. The deceased was found face down at [redacted] on 18th September 2018 after concern was raised for his welfare. The accommodation was "supported living accommodation" for vulnerable individuals. The deceased had a history of drug misuse and was on a methadone programme. He was also prescribed pregabalin by his GP. The cause of death given after a post mortem examination was :- 1a Gastric aspiration. 1b Pregabalin and methadone use. 1c – II -
4	**CIRCUMSTANCES OF THE DEATH** The deceased was found face down unresponsive in his supported living accommodation on 18th September 2018 after concern was raised for his welfare. He had a history of difficulties with illicit drugs and was on a Methadone prescription which was managed by the "One Recovery Clinic". He was also prescribed a number of medications by his GP. A Post Mortem examination together with toxicology provided that he had died from the effect of gastric aspiration due to Pregabalin and Methadone use.
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 evidence revealed a clear pattern of "medication seeking behaviour" with his GP to obtain additional amounts of Pregabalin. The evidence also showed that his GP was not aware that he was on a current Methadone script. The "One Recovery" clinic operated a system which was dependent upon the service user declaring which GP practice they were registered with. This was not checked or verified independently and therefore concern must exist that the GP may be unaware that a patient is on an

	opiate replacement regime, prescribed by another organisation, and may therefore prescribe medications which may not be suitable and which may potentially be harmful. It is suggested that, where patients are prescribed medication as part of "opiate replacement therapy", GPs have the means to check the details and the organisation providing such a service. This puts in place a more robust system to ensure that the current GP is fully aware of the treatment programme.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you or your organisation has 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 **30th August 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: 1. [redacted] Well Street Medical Centre, Well Street, Cheadle, Staffs, ST10 1EY 2. Keoghs Solicitors (instructed by Rethink Mental Illness 3. One Recovery 4. [redacted] (daughter of the deceased) 5. [redacted] (brother of the deceased) 6. [redacted] (father of the deceased) 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	01/07/2019 Signature_____ Andrew Barkley Senior Coroner **Stoke-on-Trent & North Staffordshire**