REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO [redacted] Senior Partner, Heaton Moor Medical Group, 32 Heaton Moor Road, Heaton Moor, Stockport, SK4 4NX

CORONER

I am Chris Morris, Area Coroner for Manchester South.

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

INVESTIGATION and INQUEST

On 3rd July 2019, I opened an inquest into the death of Kathryn Mary Barrow, who was found dead on 7th March 2019, aged 59 years. The investigation concluded at the end of the inquest which I heard on 23rd August 2019.

The evidence heard in court did not therefore confirm by what means Kathryn Barrow came by her death. At the end of the inquest, I therefore recorded an Open conclusion.

CIRCUMSTANCES OF THE DEATH

Kathryn Barrow was found dead at her home on 7th March 2019. She had a long history of mental illness, and had received care and treatment for bipolar affective disorder both by mental health specialist services and doctors at the practice. Mrs Barrow was prescribed a variety of medication, which she supplemented with illicit drugs.

A post mortem examination did not establish a medical cause for Mrs Barrow's death. Toxicological tests suggested Mrs Barrow had used Diazepam, Cannabis and Olanzapine in the period leading up to her death. Whilst such tests did not identify any evidence of overdose, their results must be regarded with circumspection due to the effects of decomposition.

An investigation by Greater Manchester Police concluded there were no suspicious circumstances surrounding Mrs Barrow's 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. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

1. Having claimed this has been advised by her Consultant Psychiatrist, Mrs Barrow has obtained short course prescriptions for Diazepam from the surgery apparently without

further documentation being received from mental health services to confirm this, or without further checks being made by the GP;

2. From the evidence heard at court, doctors at the practice prescribing Diazepam to Mrs Barrow do not appear to have sought to ascertain whether or not she may have access to this medicine illicitly;

3. The court heard evidence that the practice has not recently undertaken any review of its approach to prescribing Diazepam.

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.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 14th November 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

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to [redacted] on behalf of the family.

I have sent a copy of my report to Stockport Clinical Commissioning Group, the Care Quality Commission, and [redacted] (Controlled Drugs Liaison Officer, Greater Manchester Police) 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.

Dated: 19th September 2019

Signature:

Chris Morris HM Area Coroner, Manchester South.