REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: **Stockport Clinical Commissioning Group**
1	CORONER I am Alison Mutch , Senior Coroner, for the Coroner Area of Greater Manchester South
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 January 2021 I commenced an investigation into the death of Elaine Inns .The investigation concluded on the 21st July 2021 and the conclusion was one of accidental death . The medical cause of death was 1a Combined toxic effects of ethanol, gabapentin, amitriptyline, tramadol and oxycodone
4	CIRCUMSTANCES OF THE DEATH On 18th January 2021 Elaine Michelle Inns was found at her home address [redacted], Leamington Road. Police enquiries found that there were no suspicious circumstances and no evidence of third party involvement in her death. Post mortem examination included toxicology and found an excessive amount of alcohol in her system, which in combination with prescribed painkillers had led to her death.
5	<u>CORONER'S CONCERNS</u> 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 Elaine Inns continued to be prescribed a combination of medication including a number of powerful painkillers

	although it was well understood that she was also using alcohol in significant quantities whilst taking her prescribed medication. The evidence before the court also indicated that she would use the prescribed liquid morphine without clearly following the recommended dosage instructions. She continued to be prescribed it.
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 21st October 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 following Interested Persons namely [redacted] (family of the deceased), 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	**26th August 2021** **Alison Mutch** **HM Senior Coroner Greater Manchester South**