REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chief Executive Greater Manchester Integrated Care Partnership Board**
	CORONER I am Joanne Kearsley, Senior Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 20th February 2023, I commenced an investigation into the death of Stephen Ratclife, date of birth 6th October 1968 who died on the 6th February 2023 at his home address [redacted]. The medical cause of his death was confirmed as 1a) Respiratory Depression due to 1b) Combined Drug Toxicity 2) Developing Liver Cirrhosis and Anxiety and Depression.
4	**CIRCUMSTANCES OF DEATH** Stephen had a history of illicit drug and alcohol use. Had also had a diagnosis of depression and anxiety. He was under the local drug and alcohol services and for 11 months had been abstinent. He engaged well with his GP. In November 2022 he relapsed and in December 2022 was expressing suicidal thoughts. On the 10th January 2023 he collected his weekly methadone prescription. This was the last contact anyone is known to have had with Mr Ratcliffe until he was found deceased on the 6th February 2023. He had not collected his subsequent presciptions. During the course of the Inquest the court heard evidence that enquiries were also being made of his physical health in particular the need for him to have a blood test HBAc1 to check for diabetes. Due to difficult venous access these blood tests were not done.
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:- 1. The court heard that due to the deceased having compromised venous access as a result of his drug use, the GP practice were unable to take his bloods. The evidence before the court was that there is no specialist service for GPs to refer a patient to for bloods when venous access is difficult. Evidence was heard that this had been raised previously to the CCG. As a result, in this case no test for diabetes was obtained.

W	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 26 October 2023. 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:- The family of Mr Ratcliffe 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 from. 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	Date 1-9-2023. Signed: Yeatley