REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Home Office 2 Marsham St, London SW1P 4DF **Andrew Stephenson MP for the Department of Health and Social Care.**
1	**CORONER** I am, Christopher Murray Assistant 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 2nd December 2021, I commenced an investigation into the death of Steven Bowker. The investigation concluded on the 23rd June 2022 and the conclusion was one of **Drug related death**. The medical cause of death was **1a) [redacted] toxicity ([redacted]) and (II) Alcoholic hepatic cirrhosis, hepatitis C and hepatocellular carcinoma.**
4	**CIRCUMSTANCES OF THE DEATH** **Steven Bowker fell from garden ladders in 2016 whilst gardening. He landed on his elbow and was in considerable pain which ultimately affected his work causing him, in part, to leave his job. He was prescribed [redacted] which is an opioid. He remained on [redacted] for several years and developed an addiction to his medication. He was taking a cocktail of pain relief and was unable to reduce his dependency on his medication, particularly [redacted]. His relationships suffered and he became withdrawn from friends and family. He was not responding to phone calls and ultimately the police were called to attend the property [redacted] Manchester Road where Mr Bowker was found unresponsive and pronounced dead at his home address [redacted] Manchester Road, Altrincham on 1st December 2021. The cause of death was [redacted] toxicity, [redacted] confirmed following toxicological analysis of blood and urine samples.**
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. – I am concerned by the dangers to patients in respect of the prolonged prescription and use of opiate medication.
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 Monday 29th January 2024. 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], Steven's widow. 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	**2nd December 2023**