REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1) Royal College of General Practitioners 2) Greater Manchester Integrated Care Board
1	CORONER I am Alison Mutch, Senior 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 17th May 2024 I commenced an investigation into the death of Paul Michael Clark. The investigation concluded on the 8th October 2024 and the conclusion was one of accidental death. The medical cause of death was drug toxicity.
4	CIRCUMSTANCES OF THE DEATH On 12th May 2024, Paul Michael Clark was found unresponsive at his home address [redacted]. Post mortem examination included toxicology. He was found to have high and fatal level of his prescribed zomorph and pregabalin in his system.
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 evidence that Paul Clark had previously been addicted to heroin. He had been successful in treating his opioid addiction and had remained opioid free for many years. His previous problems with opioids and

	the risks of opioids for him were well documented within his medical notes. However despite the risks opioid painkillers presented to him he had been started in primary care on opioid based painkillers for reported pain. He had become addicted to them and took them at increasing levels topping them up with non-prescribed opioids. There was no evidence before the inquest that the inherent risks of reintroducing opioids to someone who had previously been addicted to them were considered or monitored. It was accepted in evidence that whilst opioid painkillers can be helpful for treating some patients the risks of treating a patient with a former opioid addiction with opioids were significant and that there needed to be a very well thought out rationale with careful monitoring to avoid increasing the chances of a patient relapsing into addiction through GP prescribed medication and that it was essential that GPs considered this when prescribing.
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 11th December 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 Archwood Medical Practice, [redacted] on behalf of the family, 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	**Alison Mutch** **HM Senior Coroner**  16/10/2024