REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1) Flixton Road Medical Centre 2) Greater Manchester Integrated Care Board
1	CORONER I am Alison Mutch , senior coroner, for the coroner area of 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 1st October 2024 I commenced an investigation into the death of Louise Danielle ROSENDALE. The investigation concluded at the end of the inquest on 17th March 2025. **The conclusion of the inquest was accidental death. The medical cause of death was 1a) Multiple drug toxicity and Pneumonia**.
4	CIRCUMSTANCES OF THE DEATH Louise Danielle Rosendale was prescribed long term opiates for pain following previous surgery. On 24th September 2024 she was found unresponsive at [redacted]. A post-mortem found she had died from a combination of multiple drug toxicity and pneumonia.
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 could 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 Louise Rosendale had been prescribed opiates for many years despite the risks associated with long term opiate prescribing. The evidence before the inquest was that there had been very limited attempts to review the long term prescribing of opiates to her. The inquest was told that she had been identified as a patient on a long term opiate prescription in 2022. The next action had been a pharmacy review in July 2024.There was no evidence of long term detailed planning or oversight of these patients within the practice
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation 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 **25th June 2025**. 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: Father of Mrs Rosendale 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. They may send a copy of this

	report to any person who they believe 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**  **30.04.2025**