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 Officer College of Policing Leamington Road Ryton-on-Dunsmore Coventry CV8 3EN **2.** [redacted] RCRP Strategic Partnership Board Broadhurst House 1st floor, 56 Oxford Street Manchester M1 6EU
	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 27th March 2025 I commenced an investigation into the death of Katie Overd. The Inquest concluded on the 7th October 2025. The medical cause of Miss Overd's death was due to : 1a) Fatal Combined Drug Toxicity 2) Ischaemic Heart Disease The conclusion of the Inquest was that the deceased died as a result of an unintended overdose of her prescribed medication on a background of longstanding inappropriate prescribing and lack of an attempted reduction of medication until 2020.
4	**CIRCUMSTANCES** Miss Overd died on the 20th March 2025 at her home address. She was 46 years old. She had a complex medical history including chronic fatigue syndrome and fibromyalgia. She was unable to leave her first floor flat due to her mobility issues. All her shopping and medication was home delivered. The level of her care needs was not fully known as she was not open to any agencies save for her GP. All GP appointments were telephone appointments as she could not attend the surgery. Since approximately 2010, Miss Overd had developed an addiction to opioids, gabapentinoids and benzodiazepines due to years of inappropriate prescribing of very high doses. In 2020 a new GP began a reduction regime but this was extremely difficult given her then addiction.

	Miss Overd had contact with her family every day via telephone. She would not allow them entry into her property and after her death 100s of packets of medication were discovered in her home. On the 19th March 2025 she had her daily evening call with her Mother. The following day her mother was not able to make contact with her daughter. She began telephoning her at 1pm and continued making approximately 30 calls before attending at her address at 7.30pm Her flat was locked with the key on the inside of the front door. As a first floor flat the family could not see into the flat. There was no doubt that Katie was inside her home as she was wheelchair/ housebound. At 20:31 the family made a telephone call was made to Greater Manchester Police. An initial question relating to whether their concern was a risk to life was not asked by the call handler. However there is no doubt family were expressing a concern for Katie's life. At the end of this call they were advised to contact North West Ambulance Service (NWAS) as it was deemed to be a medical need. At 20:37 the family called NWAS and again explained the situation. At the end of this call they were advised that an ambulance would be deployed on a category 3 (within 2 hours, albeit on the night this would likely have been longer). Given the advice provided and the level of concern the family contacted a locksmith and gained entry to Katie's home finding her deceased at 21:55 hours. It was clear from the articulate evidence given by the family that their understanding and belief of what to do in such a crisis was to contact emergency services who would respond quickly. In the first instance they were of the opinion they should ask for the police, this was due to both experience and a generally held public view. This meant they then had to repeat the same 7 minute call when advised to call NWAS. Ultimately whilst an ambulance would have been deployed it is clear for that any family in these circumstances they would likely have to wait for some hours for an ambulance as they are graded category 3. Once an ambulance had arrived at Katie's property there would then have had to be a request to deploy the fire service to gain entry. The evidence was clear if the family had had any knowledge of the Right Care Right Person process they would have sought to obtain their own locksmith at 20:31 hours and gained entry to Katie's flat sooner. Whilst in this case there was no evidence this would have prevented Katie's death, in other cases earlier entry into properties may save lives.
53.	**<u>CORONER'S CONCERNS</u>** During the course of the investigation 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.** There has been a decision made not to undertake any proactive public communications in relation to the implementation of Right Care Right Person. The court heard evidence this was both on a national and regional basis. As a result, the public who have significant concerns for the life of their family members may not seek assistance as quickly as they could do, labouring under the misapprehension that there will be a timely response from emergency services.
6	**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 9th December 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 namely:- The family of Katie Overd Greater Manchester Police North West Ambulance Service 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: 15 10 2025 Signer [redacted]