REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Manager, Adams Pharmacy, 169 Mossley Road, Ashton under Lyne**
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 4th November 2016 I commenced an investigation into the death of Steven Thomas Fone. The investigation concluded on the 23rd March 2017 and the conclusion was one of **misadventure**. The medical cause of death was 1a) **Combined toxic effects of tramadol, cocaine, amitriptyline, methadone, pregabalin and heroin.**
4	**CIRCUMSTANCES OF THE DEATH** **Steven Fone died on the 31st October 2016 at [redacted], Ashton under Lyne following the consumption of a fatal cocktail of tramadol, cocaine, amitriptyline, methadone, pregabalin and heroin.**
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. – During the course of evidence at the Inquest I was informed that Adams Pharmacy permitted three separate customers in receipt of prescriptions to interchangeably collect each other's prescriptions. No documentation was before the court to confirm whether consent had been given by any customer. I would like to know whether this practice is approved of by the relevant regulator of pharmacies. It seems to me this practice could be open to abuse and facilitate stock-piling leading to an increased risk of harm or death to those prescribed medicines which have the propensity to be fatal if taken outside the recommended guidance.
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 22nd May 2017. 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] sister of the deceased, 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	**Christopher Murray** **Assistant Coroner** **27th March 2017**