REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Department of Health, London 2. Medicines and Healthcare Regulatory Agency, London
1	**CORONER** I am Ms L J Hashmi, Area 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 21st December 2017I commenced an investigation into the death of **Ian Paul Wolstenholme,** concluding by way of inquest on the 6th August 2018.
4	**CIRCUMSTANCES OF DEATH** Against a backdrop of pre-existing co-morbidities (including Diabetes Mellitus and associated neuropathy), chronic alcoholism and a history of heroin addiction (under long-term treatment), the deceased was found in a collapsed state at his home address on the 17th December 2017. Emergency services were summoned. Paramedics confirmed the fact of the deceased's death later the same day. The deceased had a complex medical history and was prescribed a significant number of medications (polypharmacy), all of which were clinically indicated and prescribed with caution. At the time of his death the deceased remained under review by secondary care Diabetologists and the substance misuse service. His GP's involvement in the management and review of his medication was therefore minimal. Whilst clinicians were of the overall view that the deceased was compliant with his medication regime, the evidence suggested that he tended to hoard some medication yet take others as prescribed. The police investigation identified large amount of medication at the deceased's home address, including 112 unused bottles of Methadone. Whilst the deceased was on balance, afforded some degree of tolerance, his variable compliance had a material bearing upon this. Furthermore the presence of liver cirrhosis identified at post mortem examination, more likely than not, impacted upon his ability to metabolise medication resulting in a degree of accumulation. The combination of the drugs identified by way of toxicological analysis brought about a respiratory depressant effect, resulting in the deceased's death. There was no evidence to suggest that the deceased deliberately took any of his medication to excess, with the intent to harm himself.

	The medical cause of death was: 1a) Combined drug toxicity (Codeine, Morphine, Pregabalin, Methadone) 1b) – 1c) – 2) Liver cirrhosis, Diabetes Mellitus My Conclusion was: 'Drug related death to which natural, pre-existing co-morbidities more than minimally contributed'.
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:- 1. During the course of the evidence, it became apparent that there is no guidance – national or otherwise - available to Clinicians such as GPs, Hospital doctors etc. on the how best to approach the prescribing of highly addictive and potentially very harmful drugs alongside one another. In this case, the deceased had been legitimately prescribed three different types of neuropathic analgesia (including Pregabalin), alongside other opiate based medications. Whilst such drugs are almost always prescribed for very good clinical reason/s, this type of polypharmacy gives rise to the potential risk of serious harm/death. I believe that guidance would help to prevent future deaths from combined drug toxicity.
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 3rd October 2018. 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 deceased's family - Bury/Rochdale Oldham CCGs - NHS England - Public Health England - Royal Pharmaceutical Society - Royal College of Physicians - Royal College of General Practitioners - MIDAS (Drugs & Alcohol) (sent to all the above for information purposes only)

	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: 8th August 2018 Signed: