**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS**

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| | REGULATION 28 REPORT TO PREVENT FUTURE DEATHS<br><br>THIS REPORT IS BEING SENT TO: The Chief Executive of Tameside Clinical Commissioning Group (CCG) |
| 1 | CORONER<br><br>I am Alison Mutch ,Senior Coroner, for the coroner area of South Manchester |
| 2 | CORONER'S LEGAL POWERS<br><br>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<br><br>On 4th June 2018 I commenced an investigation into the death of Cady James Stewart. The inquest concluded on the 14th December 2018 and the conclusion was one of suicide<br>The medical cause of death was 1a) Combined drug toxicity |
| 4 | On 3rd June 2018 Cady James Stewart was found at her home address, [redacted]. Post-mortem found a fatal combination of prescribed drugs in her system. |
| 5 | <u>CORONER'S CONCERNS</u><br><br>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.<br><br>The MATTERS OF CONCERN are as follows. –<br>1. The inquest heard that Cady Stewart's mother had died a few months before from terminal cancer. Whilst her mother was on palliative care she had been prescribed a significant amount of opiate drugs. After her death the medication was not removed by the nursing team and remained in Cady Stewart's possession. It remained in her possession even though she attempted to take her life immediately after her mother's death. She used that in combination with medication prescribed to her to take her life. |

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| 6 | ACTION SHOULD BE TAKEN<br><br>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<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 8th February 2019. I, the coroner, may extend the period.<br><br>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<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely [redacted] cousin of the deceased, who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 OBE**<br>**HM Senior Coroner**<br>**21/12/2018** |