REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Chair of Trafford Clinical Commissioning Group (CCG)
1	CORONER I am Alison Mutch , Senior Coroner, for the Coroner Area of Greater 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 13th May 2019 I commenced an investigation into the death of Catherine Mary McNamara. The investigation concluded on the 11th December 2019 and the conclusion was one of **Narrative: Died from natural causes contributed to by toxicity of prescribed medication**. The medical cause of death was **1a) Acute left ventricular failure; 1b) Coronary atherosclerosis and left ventricular hypertrophy with superimposed opiate toxicity**
4	CIRCUMSTANCES OF THE DEATH Catherine Mary McNamara was prescribed significant quantities of pain medication including opiates. On 11th May 2019 she was found in bed at her home address, [redacted] Post Mortem examination including toxicology found that she had a level of prescribed opiates in her system which in combination with over the counter medications had contributed to her death from acute left ventricular failure. The evidence indicated that she had not taken any medication after 8th May 2019 and was not seen or heard from after that date and that on the balance of probabilities she died in the early hours of 9th May 2019.
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. – The inquest heard that over a number of years the amount of prescribed opiates had increased to a level where they led her to fall asleep and fall over. After

	concerns were raised by her family, the General Practitioner and the pain clinic began to work with her to decrease the amount of prescribed opiates she received. This was challenging due to the high dose she had been on. At the time of her death she was on a high level (although it had decreased from the previous higher level). The concern raised was how she had reached such high levels initially and the understanding of the impact this had on her.
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 7th February 2020. 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] 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. 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** **HM Senior Coroner** **13.12.2019**