HM Coroner
Manchester South

Chief Coroner's Office

Via email: rule43reports@justice.gov.uk

16th December 2019
Our Ref: 13065/MG

Dear Sirs

RE: **Clive MILES**

I enclose herewith a copy of the Regulation 28 Report I have today sent to the Accountable Officer of Stockport Clinical Commissioning Group.

I will forward a copy of the response in due course.

Yours sincerely

Alison Mutch OBE
HM Senior Coroner

Coroner's Court
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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Accountable Officer of Stockport 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 3rd June 2019 I commenced an investigation into the death of Clive Miles. The investigation concluded on the 29th November 2019 and the conclusion was one of **Drug Related death**. The medical cause of death was **1a) Combined toxic effects of morphine, codeine and sertraline**
4	CIRCUMSTANCES OF THE DEATH On 31st May 2019 Clive Miles was found at his home address, 14 Laburnum Way. There were no suspicious circumstances or evidence of third party involvement in his death. Medication packs prescribed to him were found at his address in addition to an empty oramorph box. Toxicology found that he had a toxic amount of morphine, codeine and sertraline in his system. The conclusion of the pathologist was that this combination had caused his death.
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 was told that previously Clive Miles had been changed to weekly prescriptions because he had overdosed on prescribed medication when on monthly prescriptions. In the week before his death his General Practitioner had moved him back to monthly prescribing believing that the risk no longer existed based on a discussion with him about how he was at that time. There was limited evidence of any assessment of the risk or the need to change the prescribing pattern. As a result he was in possession of a significantly increased

	quantity of medication in comparison to the amount he had been restricted to on weekly prescriptions.
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 10th 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 Mrs Erica Miles, mother of the deceased, 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** **16.12.2019**