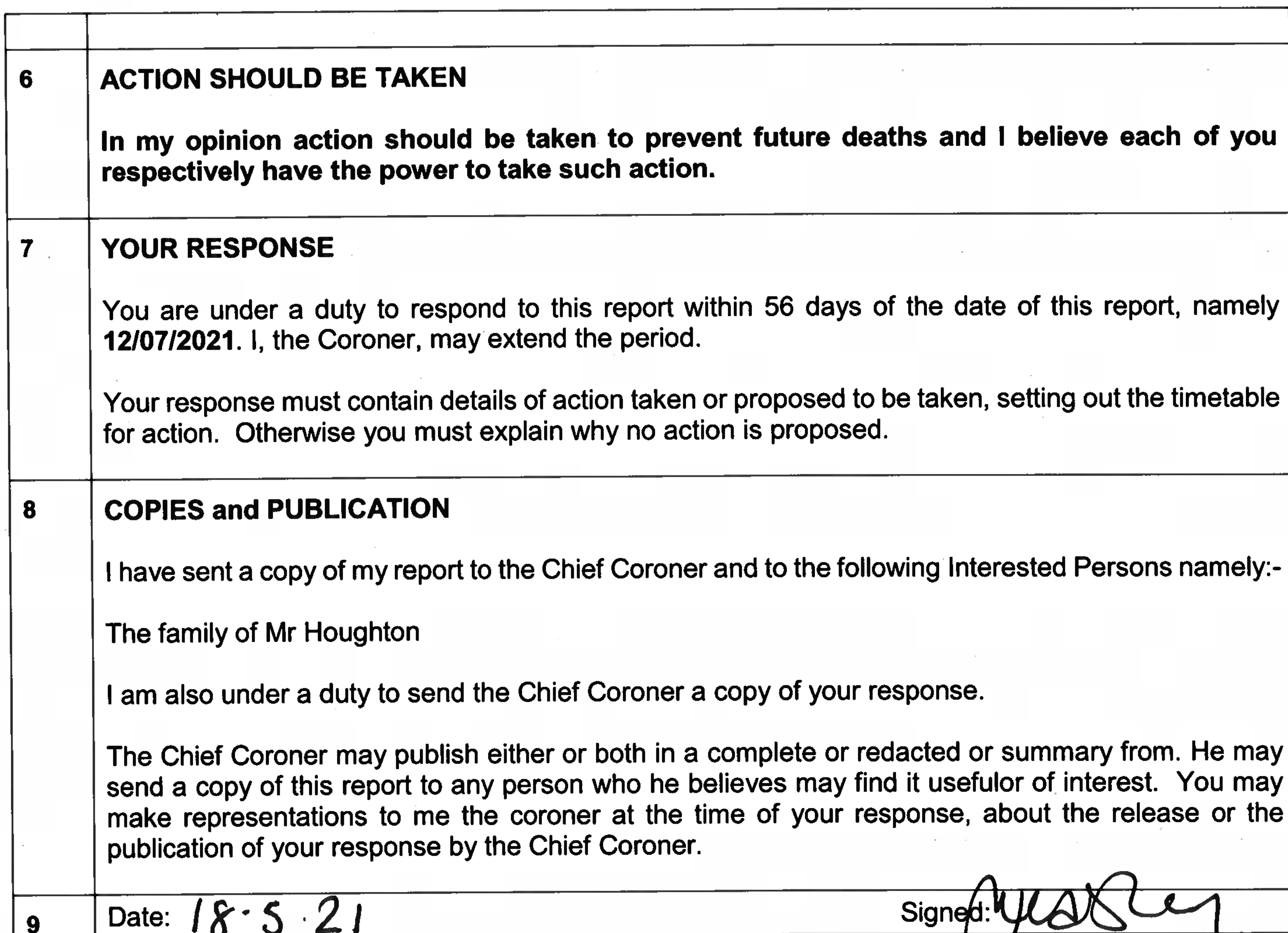
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Secretary of State for Health **2.** Manchester Health and Social Care Partnership **3.** The Uplands Medical Practice
1	**CORONER** I am Joanne Kearsley, Senior 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 17th August 2020 I commenced an investigation into the death of **Bruce Lee Houghton** the Inquest concluded on the 30th April 2021.
4	**CIRCUMSTANCES OF DEATH** 1. Mr Houghton had a number of significant physical health issues. He was prescribed Olanzapine, Ramipril, Atorvastatin, Co-Codamol, Fluoxetine, Omepraxole and Metformin. Due to memory issues his medication was kept locked away from him and he would be given this by his carers. In addition to his prescribed medication he had developed an addiction to butane gas and due to his levels of pain he would regularly purchase over the counter-medications which he would take an excess of, partly due to his memory loss. The evidence before the court was that if the GP had been aware of the amount of paracetamol the deceased was purchasing then this would have led to her considering whether he required the co-codomol prescription, which he had been receiving for years and whether further investigation as to his pain was required. Mr Houghton died on the 16th April 2020 at his home address. His medical cause of death was due to 1a) Combined Drug toxicity with the toxicology report indicating he had an excess of paracetamol levels which in turn had likely led to damage to his liver causing his other medications to accumulate. There was no evidence he intended to end his life and a conclusion of misadventure was recorded.
5	**<u>CORONER'S CONCERNS</u>** 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:- 2. The Court heard the deceased had not had his annual medication review. The court heard evidence that at these reviews the patients are not asked about any over the counter medication they may purchase in addition to their prescribed medication.



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 **12/07/2021**. 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 family of Mr Houghton 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 usefulor 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: 18·5·21 Signed: