REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Dr [redacted], Medical Director, Trafford CCG [redacted], Interim Chief Officer, Greater Manchester Health & Social Care Partnership
1	CORONER Christopher Morris, Area Coroner for 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	INVESTIGATION and INQUEST On 30th June 2021, Alison Mutch OBE, Senior Coroner, opened an inquest into the death of Michelle Jeffries who died at her home on 27th March 2021, aged 42 years. The investigation concluded at the end of the inquest which I heard on 22nd October 2021. A post mortem examination determined that Ms Jeffries died as a consequence of the combined toxic effects of [redacted] By way of conclusion, I recorded that Ms Jeffries died by way of an accident.

4	CIRCUMSTANCES OF THE DEATH Ms Jeffries had a complex medical history which was associated with her experiencing chronic and debilitating pain. For many years, Ms Jeffries had been prescribed large quantities of analgesic medication, including opiates. Whilst numerous health professionals were involved in Ms Jeffries's care over the years, and her GP Practice undertook regular medication reviews in accordance with practice procedures, the evidence before the court suggested there was a lack of involvement from pain specialists.
5	CORONER'S CONCERNS The MATTERS OF CONCERN are as follows. – It is a matter of concern that there is an absence of local guidance as to: 1. The circumstances in which GPs can safely oversee the prescription of multiple analgesics at high doses in the community, attempting to reduce reliance on such medication as indicated; and 2. When referral to a pain specialist is mandated.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 17th January 2022. 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 [redacted] on behalf of Ms Jeffries's family. I have also sent a copy to Dr [redacted], General Practitioner, 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	Dated: 22nd November 2021 Signature: Christopher Morris HM Area Coroner, Manchester South