REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Chief Executive of Tameside and Glossop Clinical Commissioning Group (CCG), Chief Executive of Greater Manchester Health and Social Care Partnership
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 8th August 2019, I commenced an investigation into the death of Wendy Margaret Wilkes .The investigation concluded on the 18th February 2020 and the conclusion was one of **Narrative: Alcohol related death exacerbated by concomitant use of medication.** The medical cause of death was **1a) Ethanol toxicity on a background of concomitant use of gabapentin, zopiclone, diazepam and amitriptyline; II) Alcohol related fatty liver disease**
4	CIRCUMSTANCES OF THE DEATH Wendy Margaret Wilkes was found on 6th August 2019 at her home address, [redacted] Denton. Toxicology found ethanol at a fatal level along with evidence of concomitant use of gabapentin (prescribed), zopiclone, diazepam, and amitriptyline (prescribed) in her blood and urine which would have exacerbated the depressant effects of the alcohol on her central nervous and respiratory system.
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. – The inquest heard that there was no clear system of alert notes/follow up review appointments at her GP practice despite the extent of the prescribed medication; The inquest heard that the GP practice did not appear to have a system to ensure that prescribers were aware that her alcohol use was high and to assess the risk of mixing alcohol with the prescribed medication.
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 15th June 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 1) [redacted] husband of the deceased; 2) [redacted] son of the deceased; 3) Haughton Thornley Medical Centre, 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** **20.04.2020**