REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Medicines and Healthcare Products Regulatory Agency (MHRA)**
1	**CORONER** I am Rachel Galloway, assistant coroner, for the coroner area of South Manchester
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 the 20th January 2017 an investigation was commenced into the death of Aaron John Peter McCaffrey. An inquest was opened on the 20th January 2017 and concluded on the 31st May 2017. The medical cause of death was: 1a Hypoxic brain injury b Multiple cardiac arrests c Loperamide overdose The Coroner's Conclusion was: "drug-related" death.
4	**CIRCUMSTANCES OF THE DEATH** Mr McCaffrey had a history of taking large quantities of loperamide medication. This is a medication that is available "over-the-counter" and is often referred to under the brand name "Imodium". Mr McCaffrey had a history of addiction to opiate medications, which dated back a number of years. This included addiction to medications such as co-codamol. However, he later developed an addiction to loperamide medication and – in the years prior to his death – he was known to regularly take in the region of 150 tablets per day. Mr McCaffrey's ex-partner explained in evidence that this was the amount that Mr McCaffrey would admit to taking but she suspected that he took more than this on occasion. It was clear that the history of addiction was part of the reason for the relationship breakdown, although [redacted] remained in close contact with Mr McCaffrey, as they had young children together. Loperamide medication contains a low level of opiate. Mr McCaffrey was known to suffer from anxiety, although he kept any mental health concerns mainly to himself. He told [redacted] that he took large amounts of loperamide medication because it made him feel better. On the 13th January 2017 Mr McCaffrey took in the region of 250 loperamide tablets. He collapsed in the toilets at the Tesco Store in Droylsdon, Manchester and was taken by ambulance to Tameside General Hospital. His condition deteriorated in hospital (despite medical treatment) and he died on the 19th January 2017. The Conclusion was recorded as: "drug-related death". Mr McCaffrey did not intent to end his own life. His death was an unintended consequence of consuming the large amount of loperamide medication.

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. – Mr McCaffrey's ex-partner gave evidence that Mr McCaffrey would regularly purchase large quantities of loperamide medication. Following the incident on the 13th January 2017, she counted 250 tablets that had been taken (the empty packets were in the back-pack in his possession). The receipts were also present within the bag. She advised that he had purchased large amounts of this medication from a budget store as well as smaller quantities from a supermarket and a chemist. It was clear that Mr McCaffrey would frequently buy large amounts of this medication from a single store. The concern is that there is no apparent limit on the amount of loperamide medication that can be purchased from a single store. This makes the medication easier to purchase in large quantities. I am concerned that action should be taken to limit the amount of loperamide medication that can be purchased from a single store, due to the fact that it is apparently being used (on occasion) to fuel addiction and due to the risk of overdose and death.
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 11th August 2017. 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: [redacted] (ex-partner) and [redacted] (mother of Mr McCaffrey) 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	**Rachel Galloway** **Assistant Coroner** **16.06.2017**