REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Longshoot Health Centre, Scholes, Wigan
1	**CORONER** I am Jennifer Leeming, H M Senior Coroner, for the Coroner Area of Manchester West
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 25th October 2013 I commenced an investigation into the death of Kyle Ashley Smith, 27. The investigation concluded at the end of the inquest on 9th January 2014. The conclusion of the inquest was an Open Verdict with the cause of death being 1a) The combined Toxic Effects of Tramadol, Codeine and Zopiclone.
4	**CIRCUMSTANCES OF THE DEATH** (a) On the morning of the 19th of October 2013 Kyle Smith's wife tried to rouse him but he did not respond. She summonsed an ambulance and when the ambulance crew attended they told her that Mr Smith, who was then aged 27, had died. A subsequent Post Mortem examination including toxicological testing of samples revealed that the medical cause of Mr Smith's death was that it was due to the combined toxic effects of Tramadol, Codeine and Zopiclone. (b) Mr Smith had a history of what his GP described as "mood problems" dating back to 2005. On the 15th of October 2013 Mr Smith saw his GP because, again as his GP describes, Mr Smith and his wife were becoming increasingly concerned with regard to Mr Smith's mood swings and his self harming behaviour. Mr Smith had been harming himself by cutting his arms with razor blades, and his GP gave evidence at the Inquest that she had been shocked by the number and nature of the cuts that Mr Smith had inflicted upon himself. (c) As a consequence of this Mr Smith's GP decided to refer him urgently to the Wigan and Leigh Assessment team of the Five Boroughs Partnership

	NHS Foundation Trust, which is a Mental Health Trust. Accordingly on the 16th of October 2013 Mr Smith's GP wrote a letter of referral to the team, which she marked "URGENT". That letter was received by the Assessment Team by fax at 13.04 hours on the 18th of October 2013. Mr Smith's GP was unable to explain the delay in the urgent referral being sent in her evidence at the Inquest and no investigation into that delay had been made. (d) On the day that the referral was received a member of the Assessment Team attempted to contact Mr Smith by telephone without success. A further attempt was made the following morning, but by that time Mr Smith had died.
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: (1) Mr Smith's GP was concerned about his mental health when she saw him on the 15th of October 2013, to the degree that she decided to refer him urgently to the Mental Health Assessment Team. (2) That referral did not reach the Team until the 18th of October. (3) The reason for this delay has not been investigated and is not currently known.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and/or 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 18th March 2014. 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 1) [redacted] Wife of the Kyle Ashley Smith. 2) Mr Simon Barber, Chief Executive, 5 Boroughs Partnership NHS Foundation Trust, Hollins Park House, Hollins Lane, Winwick, Warrington, WA2 8WA.

	3) [redacted] all of Longshoot Health Centre, Scholes, Wigan. 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** **21st January 2014**	**Signed** MJenniferLeeming **M Jennifer Leeming**