REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Dr Peter Miller, Chief Executive, Leicestershire Partnership NHS Trust** **2.** [redacted]
1	**CORONER** I am Lydia Brown, assistant coroner, for the coroner area of Leicester City and South Leicestershire.
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 12 February 2014 I commenced an investigation into the death of Michael Anthony Tarratt DOB 3 January 1968. The investigation concluded at the end of the inquest on 10 March 2014. The cause of death was multiple drug toxicity and my conclusion was this was an accidental death.
4	**CIRCUMSTANCES OF THE DEATH** Mr Tarratt had a long known history of poly drug and alcohol abuse, and was receiving treatment for his opioid dependence. He was prescribed methadone to assist with withdrawal. It appeared that Mr Tarratt was motivated to try and reduce his dependency and seemed to be positive and forward thinking at the time of his death. He was seeing his GP and drug worker regularly in the months leading up to his death. Mr Tarratt was found deceased at his home address from the effects of multiple drug toxicity; there was no evidence of intent to take his own life.
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) Despite Evidence from the Drug and Alcohol team that it was appropriate to update the relevant GP every 3 months, or at least every 6 months, it was accepted on this occasion that no contact had been made for 18 months. Consideration should be given to more regular contact between the services providing treatment. (2) Despite Evidence that the GP prescription of tramadol (for knee pain) was inappropriate for an opiate dependent patient, no contact was made with the GP surgery

	and it was left to the patient to tell his GP. There was no evidence to suggest that Mr Tarratt did this. Consideration should be given to routine exchange of information regarding prescriptions between services, to avoid one agency counter-acting the treatment of the other. Consideration should be given to the appropriateness of asking the patient to be responsible for this communication.
6	**ACTION SHOULD BE TAKEN** In my opinion 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 9th May 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 – [redacted] (father) [redacted] (brother) [redacted] Medical Director, NHS England for Leicestershire and Lincolnshire area 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	**[DATE]** **[SIGNED BY CORONER]**