REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Ms Nerissa Vaughan, Chief Executive, The Great Western Hospital, Marlborough Road, Swindon SN1 6BB**
1	**CORONER** I am David Ridley, Senior Coroner for the Coroner area of Wiltshire and Swindon
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 17 September 2013 I commenced an investigation into the death of Andrew Michael Horgan aged 46. The investigation concluded at the end of the Inquest on 08 April 2014. The conclusion of the Inquest was that Andrew had died from:- 1a) Acute cardiac failure 1b) Colchicine overdose 2) Coronary artery atherosclerosis, myocardial fibrosis, focal incomplete hepatic cirrhosis. I concluded that Andrew Horgan's death was as a result of an accident – an unintended consequence of a deliberate act.
4	**CIRCUMSTANCES OF THE DEATH** Andrew had recently split up with his girlfriend and was admitted to the Great Western Hospital in Swindon at 0018 on 14 September 2013 having over the previous 12 hour period consumed a variety of drugs including Colchicine with alcohol (other drugs included Clomethiazole and Dihydrocodeine). I found as a matter of fact that more likely than not Andrew himself called the ambulance from his flat at Flat 1 Daniel Gooch House, Rodbourne Road, Swindon. Following admission his condition was monitored, he was given intravenous fluids and whilst his Glasgow Coma Scale fluctuated the following day shortly after 1500 hours he requested that he self-discharge from hospital (GCS normal at this stage). [redacted] spoke to him having appraised himself as regards the background to the case and was satisfied that Andrew had full mental capacity and understood the ramifications of his decision to leave hospital. He did not form the view that Andrew posed a risk of further self-harm, Andrew having indicated the reason for him wanting to leave was in respect of a meeting with his landlord. Following self-discharge Andrew was dropped off at his mother's home and she walked him round to Andrew's flat and spent about an hour with him. They had further contact on Sunday 15 September 2013 and Andrew was last known to be alive at 1715 that evening. Andrew's body was discovered at approximately 1600 hours on Monday 16 September

	2013 lying on the floor of his bedroom fully clothed at his flat. His death was confirmed by an attending paramedic at 1655 the same day. The examination after death revealed that Andrew had a compromised cardiovascular system reducing cardiac reserve as well as reduced hepatic reserve both of which contributed to his death as a result of acute cardiac failure which was attributable to the Colchicine overdose. The evidence that I had before me was that Colchicine remains in the body for some time and it can take a number of weeks to fully recover from an overdose. There is also no antidote as such to the drug.
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 duty to report these concerns to you. The **MATTERS OF CONCERN** are as follows. – 1. Training for Doctors and other medical staff in relation to referring patients for assessment both within the hospital and externally following discharge. – During the course of the Inquest [redacted] gave evidence and it was quite clear that he did not have a clear understanding of the referral procedure to involve professionals from the Avon and Wiltshire Mental Health Partnership. He believed his telephone conversation with the Swindon Intensive Services with CPN [redacted] would result in the outreach team assessing Andrew in the community. He thought that a telephone call alone would be sufficient in that respect to engage the Mental Healthcare professionals. The importance of a clear and effective communication pathway following recognised and agreed practices and procedures cannot be ignored and I am concerned following the evidence I heard there were knowledge gaps as regards practice and procedures to be followed when engaging Mental Health Partnership personnel. I would be grateful if you could please review the appropriateness and the effectiveness of training in this respect not only for current GWH personnel but also how effective training in this area can be given to personnel in the future. Whilst I was satisfied that this did not contribute to Andrew's death in this instance my concern is that an issue could arise in the future whereby that may not be the case.
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 03 June 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] Mr Simon Stevens, Chief Executive, NHS England,

	Mr Iain Tulley, Chief Executive Avon and Wiltshire Mental Health Partnership NHS Trust. 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	 **08 April 2014** **HM Senior Coroner**