	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Priory Group Ltd. Priory House, Randalls Way, Leatherhead, Surrey KT22 7TP**
1	**CORONER** I am Andrew Tweddle, senior coroner, for the coroner area of County Durham and Darlington
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. (see attached sheet)
3	**INVESTIGATION and INQUEST** On 9/4/2014 I commenced an investigation into the death of **David Peter Greenfield**, aged 29 years. The investigation concluded at the end of the inquest on 26th November 2014. The conclusion of the inquest was "The deceased died unexpectedly as a result of his pre-existing natural heart disease combined with respiratory depression linked to obesity and the effects of the ingestion of drugs".
4	**CIRCUMSTANCES OF THE DEATH** The deceased at the time of his death was aged 29 years. He was obese and weighed 195 kilograms. He had abused alcohol and drugs for some years and had been prescribed methadone at a high daily dosage for a number of years. He was admitted to the Priory Hospital , Aspen Unit, Middleton St George at 12.30 p.m. on Wednesday 2nd April 2014. He was assessed as a high risk patient and was subject to four observations per hour. He self admitted to the hospital to take part in an alcohol detoxification programme where no variation to his daily methadone intake was planned. There was confusion as to the amount of methadone the deceased had taken prior to admission and what he was to take and when on his first day of admission. In the event it would appear that the deceased took less methadone than he had been prescribed. He was prescribed Chlordiazepoxide as part of his alcohol detoxification process. He was breathalysed on admission and on subsequent occasions during his stay. No drugs screen was undertaken. The deceased was found unresponsive in his bedroom at 04.45 hours on the 3rd of April, i.e. less than 24 hours after admission. At post mortem it was found that he had ischaemic heart disease and that together with respiratory depression caused by drugs and his obesity led to his death.
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. Not everyone involved in his care was experienced in dealing with patients who had both drug and alcohol problems and the risks of respiratory depression in patients such as the deceased were not fully appreciated. The internal enquiry undertaken by The Priory following the deceased's death took into account experience and opinions of people within the organisation but did not draw upon research undertaken outwith the organisation on the question of sudden and unexpected deaths of people taking prescribed methadone. A re-training programme had been introduced by The Priory following this death but it would

	seem that there remains a lack of a detailed appreciation of the risks involved of death of patients in receipt of methadone and of patients with the particular characteristics of the deceased and therefore until that understanding and appreciation of risk has been determined training which has already being instigated cannot properly deal with issues which have yet to be identified. It is therefore believed that a further review of such risk and risk management policies needs to be considered with suitable re-training introduced thereafter. 2. Evidence was given if a patient enters The Priory with a view to a drug treatment issue then that patient would be screened for drugs. If a patient is admitted to The Priory for an alcohol detoxification programme then there is no screening for drugs. The deceased was known to take methadone. Other drugs were found at post mortem in his system and in combination with alcohol detoxification medication there is an increased risk of respiratory depression and in the absence of the prescribing doctor knowing with a degree of certainty (notwithstanding any statements made by a patient) as to what drugs are in a patients system then a full and proper risk assessment as to the nature of the treatment to be offered and the level of supervision and observations to be instituted (i.e. a meaningful risk assessment) cannot be undertaken and this lacuna in admission procedures could well lead to an increased risk of similar fatalities in the future.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 26th January 2015 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 Beachcroft Solicitors [redacted] Royal College of Nursing MPS Solicitors DWF Solicitors [redacted] 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 27TH November 2014 SIGNED: ..... ANDREW TWEDDLE LLB H M SENIOR CORONER COUNTY DURHAM AND DARLINGTON