PETER G. HATVANY
Assistant Coroner for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mr Iain Tulley, Chief Executive, Avon & Wiltshire Mental Health Partnership NHS Trust, Jenner House, Langley Park, Chippenham, Wiltshire, SN15 1GG** **Secretary of State for Health, Department of Health, Richmond House, 79 Whitehall, London, SW1A 2NS**
1	**CORONER** I am PETER G. HATVANY, Assistant Coroner for 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 14 April 2015 I concluded an investigation into the death of Andrew Ralph Mitchell Farrow, aged 48 . The conclusion of the inquest was Accidental death as a result of acute alcohol and codeine toxicity.
4	**CIRCUMSTANCES OF THE DEATH** The deceased died as a result of self administered acute codeine and alcohol toxicity at his home on 7 July 2014.
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 deceased was under the care of the Avon and Wiltshire Mental Health Partnership. The day before his death the deceased made it clear he wished to be admitted to hospital for his own safety. The **MATTERS OF CONCERN** are as follows. – He was known to have suicidal ideation but no actual plan had been formulated. I did not find that he ought to have been admitted. My concern however is that had he needed admitting it is apparent no beds would have been available at Green Lane Hospital Devizes when an enquiry was made on 6 July 2014 by North Wiltshire Intensive Services.

6	**ACTION SHOULD BE TAKEN** What action would there have been taken in that eventuality? Would enquiries have been made as to the availability of other beds in other areas such as Callington Road, Bristol?
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 15 June 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 [redacted] Mother of the deceased 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 20 April 2015 Signature [redacted] Assistant Coroner for Wiltshire and Swindon

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