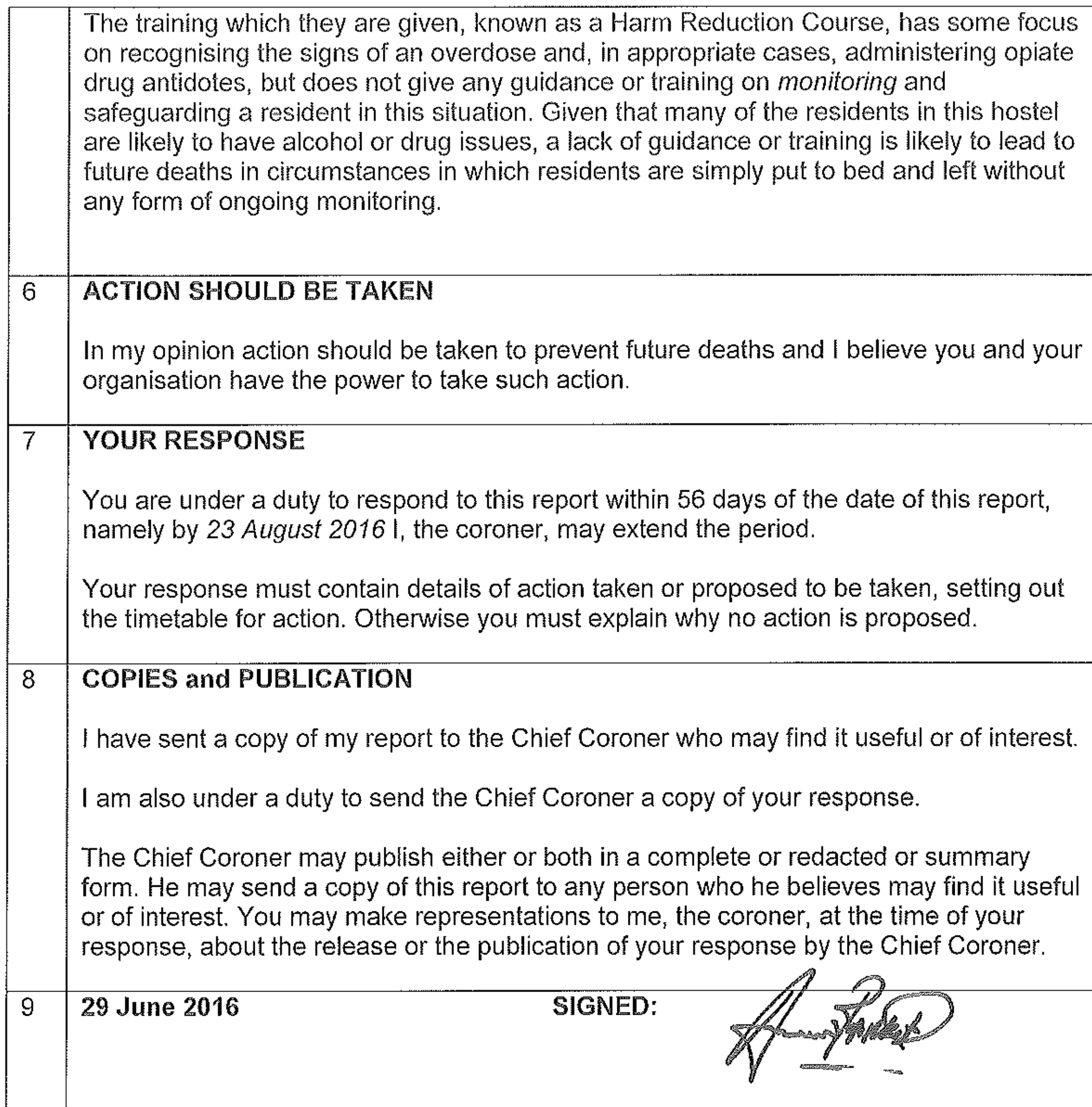
ANNEX A

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:** 1. ***Chief Executive of The Wallich Centre*** 2. [redacted] 3. **Chief Coroner**
1	**CORONER** I am Andrew Roger BARKLEY, Senior Coroner for the coroner area of South Wales Central.
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 14th April 2016 I commenced an investigation into the death of Lee Colin DAVIES aged 36. The investigation concluded at the end of the inquest on 15th June 2016. The conclusion of the inquest was a "Drug Related" and the medical cause of death was 1a.Combined Drug Toxicity and Bronchopneumonia.
4	**CIRCUMSTANCES OF THE DEATH** Lee Colin DAVIES was residing at a resettlement hostel for the homeless as from 1st April 2016 as an emergency placement. He was known to have been an intravenous user of illicit drugs for some years. In the early hours of the morning, around 0145hrs, on 9th April 2016, he was found on the floor in a toilet cubical with his trousers down and a needle in his groin. He was later assisted to his feet and taken back to his room by a fellow resident. When checked the following morning around 10am, he was discovered unresponsive lying on his bed and declared deceased shortly afterwards by the attending paramedics.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) The evidence revealed that staff, including night staff at the hostel, have no direct training or guidance on what steps should be taken when a resident is found in circumstances which suggest that they may have injected or otherwise take illicit drugs.



	The training which they are given, known as a Harm Reduction Course, has some focus on recognising the signs of an overdose and, in appropriate cases, administering opiate drug antidotes, but does not give any guidance or training on *monitoring* and safeguarding a resident in this situation. Given that many of the residents in this hostel are likely to have alcohol or drug issues, a lack of guidance or training is likely to lead to future deaths in circumstances in which residents are simply put to bed and left without any form of ongoing monitoring.
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 *23 August 2016* 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 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	**29 June 2016** **SIGNED:**