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:** **CHIEF EXECUTIVE ABMU HEALTH BOARD** **1 TALBOT GATEWAY** **BAGLAN ENERGY PARK** **BAGLAN** **PORT TALBOT** **SA12 7BR**
1	**CORONER** I am **Aled Gruffydd**, Assistant Coroner, for the coroner area of SWANSEA NEATH & PORT TALBOT
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 8th January 2016 I commenced an investigation into the death of Christopher John Llewellyn Roberts. The investigation concluded at the end of the inquest on 4 October 2017. The medical cause of death is 1a opiate toxicity The conclusion of the inquest as how Mr Roberts came to his death is a narrative one and is as follows:- The deceased died of overdose of prescription medication. The intent to take his own life could not be proven to the required standard.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was Christopher Roberts and he was pronounced dead on the 19th of October 2015 at his home address of 57 St Nicholas Square, Swansea Marina, Swansea. The cause of death was a deliberate overdose of his pain relieving opiate prescription medicine, MST Continus, with 498mcg/L of morphine being found in his blood by way of a toxicology report. Christopher was receiving treatment for mental illness by the Community Mental Health Team (CMHT). Christopher was diagnosed as having a depression and anxiety coupled with borderline personality traits. Christopher's care plan was written in February 2014 and a review was planned for February 2015. The evidence of the Community

	Psychiatric Nurse (CPN) was that the review had been carried out with no changes to the care plan, however this was never recorded. Shortly before the care plan was due to be reviewed, Christopher made an attempt on his life by way of overdose. There was no evidence or decision making trail to confirm whether this issue was considered when deciding if the care plan should remain the same. The care plan stipulated that the deceased was responsible for his medication and that this would be administered by way of a dossiette (or nomad tray) and would be prepped on a weekly basis. The evidence was that the deceased's medication regime was chaotic with tablets being taken in the wrong order or not being taken at all. This was known to CMHT by way of reports from the deceased's support worker, and from admissions by the deceased himself.
5	**CORONER'S CONCERNS** During the course of the inquest it was apparent that the decision to maintain the current care plan was not recorded and no clear decision making trail was demonstrated, particularly in view of the fact that the deceased had made an attempt on his life a few weeks before the care plan was due to be reviewed. Furthermore it was established in evidence that the deceased was not coping with taking his medication in the manner prescribed. The nomad trays were in disarray with the deceased sometimes forgetting to take some medication, and sometimes he would take medication not on the day prescribed. As such the deceased may not have received the full benefit of the medication prescribed to control his mental illness. 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. The care plan review was not recorded which would not allow another person reviewing the file to ascertain that a care plan review had taken place and what the outcome of that review was. It was also the case that a lack of documentation would not demonstrate whether CMHT had considered the matter of the attempt on his own life by the deceased in the weeks leading up to that review, when considering whether to amend or retain the care plan in place at the time. 2. Nomad trays may be unsuitable in dispensing medication to some patients, which may deprive them of the benefits in taking that medication.
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 30 November 2017. 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] 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	**5 October 2017 ..... [SIGNED BY CORONER]**