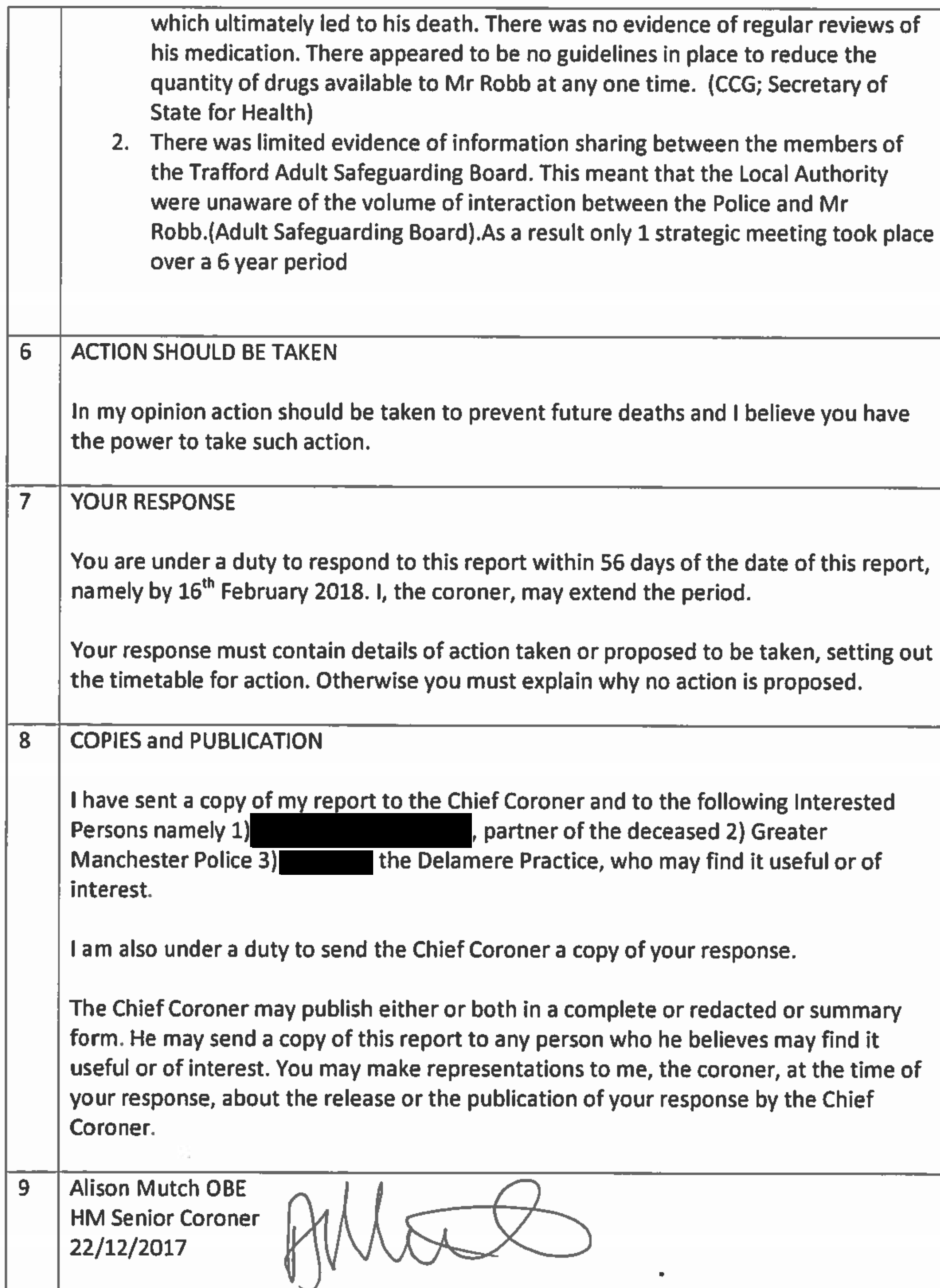
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Chief Executive of Trafford Clinical Commissioning Group, Trafford Adult Safeguarding Board.
1	CORONER I am Alison Mutch, senior coroner, for the coroner area of South Manchester
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 18th April 2016 I commenced an investigation into the death of Russell Charles ROBB. The investigation concluded on the 24th November 2017 and the conclusion of the jury was narrative: Mr Robb did not intend the outcome to be fatal. Mr Robb had taken a fatal combination of prescribed and non-prescribed drugs, mixed with alcohol. Due to Mr Robb's vulnerable mental state along with his level of intoxication, it is more likely than not that Mr Robb was unaware of the high level of substances that he consumed. Mr Robb displayed very anxious, aggressive and erratic behaviour, which were heightened after receiving a letter regarding his benefits. In the past, it is evident that there was a lack of communication between multiple agencies along with the fact that Mr Robb failed to comply and engage with professional help. There was inadequate monitoring of Mr Robb's administration of prescribed drugs. The medical cause of death was 1a Combined Drug Toxicity; and 2 Ischaemic Heart Disease
4	Mr Robb died on 9th April 2016 at 20:27pm at Manchester Royal Infirmary. Mr Robb had taken a cocktail of drugs (prescribed and non-prescribed) along with a substantial amount of alcohol prior to his death. During the early evening of 9th April 2016, Police officers forced entry to Mr Robb's property, discovering him in a collapsed state. CPR was administered by both Police Constables, the ambulance and fire service attended. The fire service attempted to resuscitate using a defibrillator. Mr Robb was transferred to A&E at Manchester Royal Infirmary, where further means of resuscitation took place. At 20:27pm, Mr Robb was pronounced dead.
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.



	which ultimately led to his death. There was no evidence of regular reviews of his medication. There appeared to be no guidelines in place to reduce the quantity of drugs available to Mr Robb at any one time. (CCG; Secretary of State for Health) 2. There was limited evidence of information sharing between the members of the Trafford Adult Safeguarding Board. This meant that the Local Authority were unaware of the volume of interaction between the Police and Mr Robb.(Adult Safeguarding Board).As a result only 1 strategic meeting took place over a 6 year period
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you 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 16th February 2018. 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 namely 1) , partner of the deceased 2) Greater Manchester Police 3) the Delamere Practice, 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	Alison Mutch OBE HM Senior Coroner 22/12/2017