REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Service Delivery Director of ADS (Addiction Dependency Solutions)
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 9th March 2017 I commenced an investigation into the death of Stuart Michael Campbell. The investigation concluded on the 28th September 2017 and the conclusion was one of Narrative: **Died as a consequence of suspension from a ligature whilst under the influence of a cocktail of drugs and alcohol.** The medical cause of death was 1a **Asphyxia;** 1 b**Fatal pressure on the neck** 1c **Hanging**
4	CIRCUMSTANCES OF THE DEATH **Stuart Michael Campbell was known to the drug and alcohol service. He was last seen on 21st February 2017 when he reported escalations in use of drugs and alcohol. He also reported feeling distressed emotionally. He was not referred by ADS to Pennine Care. On 5th March 2017 he was found suspended by a ligature at [redacted] Toxicology showed the presence of a cocktail of drugs and alcohol.**
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. The inquest was told that ADS were the lead contractor for the provision of services. The protocol between ADS and Pennine Care had an escalation policy to be followed where an ADS worker felt the needs of an individual felt the needs could not be met via ADS. An escalation had not taken place in this case. It was unclear what guidance was available to ADS workers. There was no provision for clinical support for ADS workers.

	2. Care was shared care between ADS and the GP. The GP had not seen the deceased and it was unclear how shared care discussions could be facilitated and documented.
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 25th December 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 namely; 1) [redacted] mother of the deceased. 2) Chief Executive of Oldham Metropolitan Borough Council. 3) Chief Executive of Pennine Care, 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 30/10/2017