H M Assistant Coroner for Gloucestershire
Caroline Saunders

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Gloucestershire Care Services NHS Trust, Edward Jenner Court, 1010 Pioneer Park, Gloucester Business Park, Brockworth, Gloucester, GL3 4AW**
1	**CORONER** I am Caroline Saunders, H M Assistant Coroner for Gloucestershire.
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 the 24th October 2017 I commenced an investigation into the death of **MARTIN LEE TILLEY**. The investigation concluded at the end of the inquest on **Tuesday 6th March 2018** The conclusion of the inquest was **Drug Related death**. The medical cause of death was **1a) Drug and Alcohol Toxicity**
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a long history of substance misuse. He also had a significant history of mental health problems. He had been seen by the psychiatric nurse attached to the Homeless Healthcare Team. His last appointment from the records provided to the inquest was in July 2017. On 17th October 2017, Martin Tilley was found deceased from the combined toxic effects of prescribed and non-prescribed medication.
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. – Prior to Mr Tilley's last appointment with the psychiatric nurse (CPN) attached to the Homeless Healthcare Team in July 2017 he was talking of self-harm, had suicidal thoughts and was apparently experiencing visual and auditory hallucinations. It appears that after not attending an appointment with the CPN in July Mr Tilley was no longer seen by the team. Prior to the inquest the Homeless Healthcare Team were asked to explain the circumstances in which such a presentation would result in a referral for an emergency assessment by a psychiatrist or the tertiary mental health services. No answer to this question was forthcoming. Furthermore there was no evidence that Mr Tilley was followed up by the Homeless Healthcare Team after July 2017.

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. I would like some reassurance as to the processes and guidelines that exist to ensure that vulnerable adults such as Mr Tilley who are apparently contemplating suicide are referred to specialist mental health teams, and how they are kept under review.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 4pm Monday 7th May 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 (1) The family of the deceased. (2) (3) 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 12th March 2018 Signature C Saunders Caroline Saunders H M Assistant Coroner for Gloucestershire

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