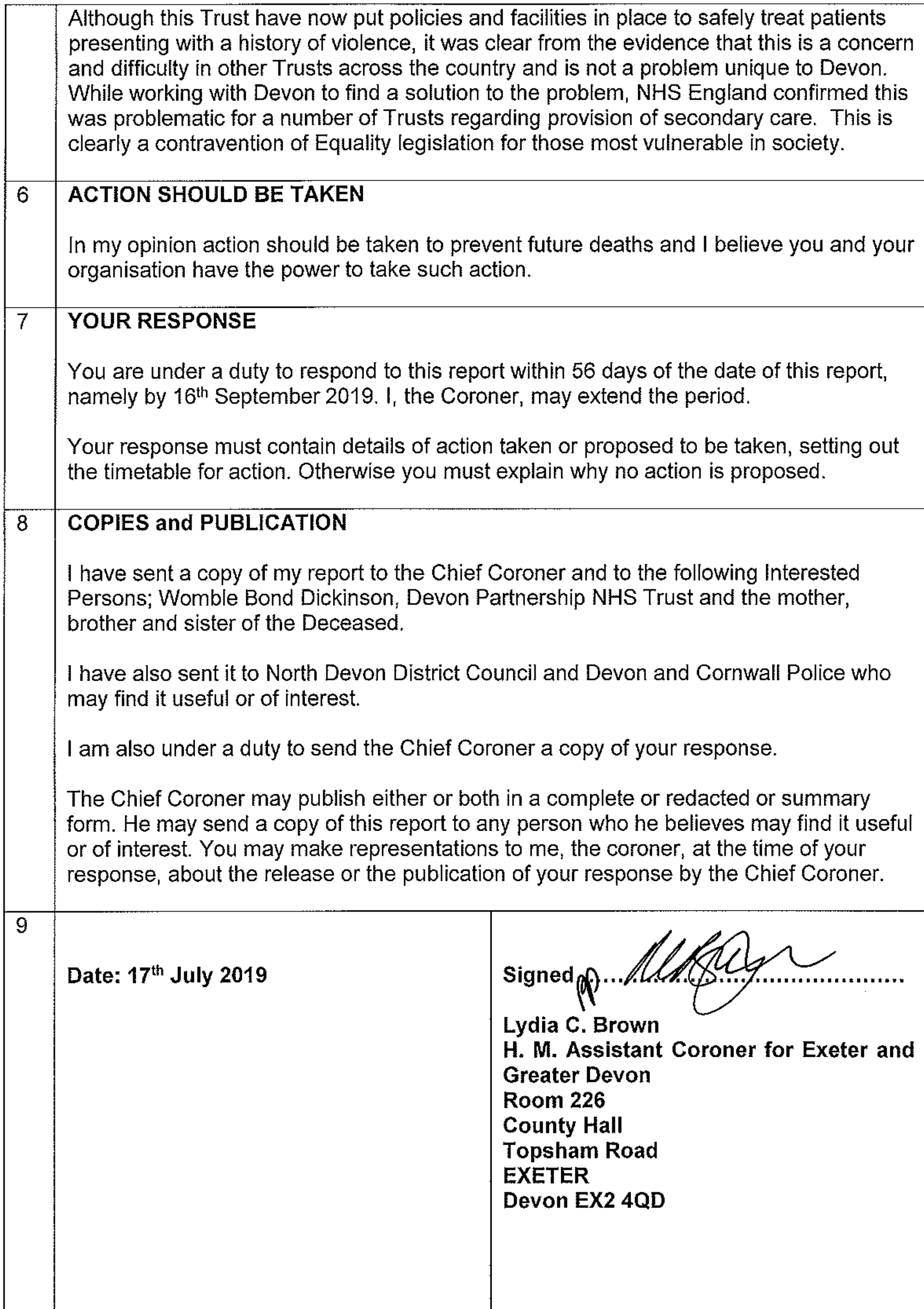
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, NHS England**
1	**CORONER** I am Mrs Lydia Brown, Assistant Coroner for the Exeter and Great Devon District
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 4th June 2018 I commenced an investigation into the death of Allan Graham Joslin, aged 44. The investigation concluded at the end of the inquest on 17 April 2019. Medical Cause of Death: Ia) Dihydrocodeine and Pregabalin Intoxication Conclusion – Drug-Related Death
4	**CIRCUMSTANCES OF THE DEATH** Allan was found deceased partially on top of a tent in the vicinity of the North Devon Leisure Centre, Barnstaple, on 23rd May 2018. He had not been seen or contacted by anyone for several days between the 18th May before the discovery of his body. Allan had been referred on two occasions by his general practitioners for a mental health assessment, but the local trust had no effective policy to facilitate this, given Allan's known previous violent behaviour. Neither assessment took place, missing an opportunity for Allan to be diagnosed and treated for his mental ill-health and dependency on drugs and alcohol. Allan did not receive an appropriate service in accordance with his needs and presenting vulnerabilities.
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. – The Devon Partnership NHS Trust had no adequate mental health care facility or safe room to deal with a patient who presented with complex needs including the need for mental health assessment, and drug and alcohol dependency issues, who was potentially violent. There was no policy in place to facilitate the general practitioners' referrals and therefore Mr Joslin received no formal assessment or treatment prior to his death. This may have impacted on his ability to receive additional services and assistance with his homeless status.



Although this Trust have now put policies and facilities in place to safely treat patients presenting with a history of violence, it was clear from the evidence that this is a concern and difficulty in other Trusts across the country and is not a problem unique to Devon. While working with Devon to find a solution to the problem, NHS England confirmed this was problematic for a number of Trusts regarding provision of secondary care. This is clearly a contravention of Equality legislation for those most vulnerable in society.

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 16th September 2019. 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; Womble Bond Dickinson, Devon Partnership NHS Trust and the mother, brother and sister of the Deceased.

I have also sent it to North Devon District Council and Devon and Cornwall Police 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

Date: 17th July 2019

Signed..

Lydia C. Brown
H. M. Assistant Coroner for Exeter and Greater Devon
Room 226
County Hall
Topsham Road
EXETER
Devon EX2 4QD