REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** The Village Medical Centre, Peel Street, Littleborough, OL15 8AQ
1	**CORONER** I am Catherine McKenna, Area Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 25 February 2019, I commenced an investigation into the death of Alex Grady. His inquest concluded on 11 November 2019 and I returned the following Narrative Conclusion: Against a background of chronic anxiety, episodes of binge-drinking, the use of prescribed and non-prescribed medication and illicit drugs, the Deceased died as a result of combined drug toxicity which had been taken at a time of heightened emotional distress. The Deceased did not intend the consequences of his actions.
4	**CIRCUMSTANCES OF DEATH** Mr Grady was 28 years old at the time of his death. He had a history of chronic anxiety, alcohol dependence syndrome and dependence on benzodiazepines. He had been abstinent from alcohol since 2013 and in November 2017, a note was placed on his GP records that he was not to be issued with any further prescriptions for benzodiazepines. He had previously used cannabis and cocaine. He was not open to Alcohol and Drug services at the time of his death and had not received input from them since becoming abstinent from alcohol in 2013. He received weekly counselling sessions from a charity with the aim of addressing his anxiety which was regarded as the underlying cause for his previous dependency on alcohol. In the 12 months before his death, Mr Grady had started to use alcohol again. He would have binges of alcohol followed by periods of abstinence. On 7 January 2019, he attended his GP practice following an episode of binge-drinking. He was tearful and declined input from the Crisis team. He was issued with a prescription of Chlordiazepoxide for use in alcohol detoxification. He returned to the GP practice on 9 January 2019 and was issued with a second prescription of Chlordiazepoxide in order to complete the seven day course. The GP offered a further follow up appointment but no appointment was made. A referral to the Alcohol or Drugs service was not made. Following the course of Chlordiazepoxide, Mr Grady began to purchase Diazepam from the internet. On 23 February 2019, following another episode of binge-drinking session, Mr Grady slashed his face with a knife whilst intoxicated and in a very distressed state. He expressed thoughts of wanting his life to end. Police and paramedics attended and he was taken to Fairfield General Hospital. Information relayed by Mr Grady's mother, that he had been purchasing diazepam on the internet was handed over to the A&E staff. The A&E doctor assessed the wound to be superficial and referred Mr Grady to the mental health team because he had expressed the wish that his life would end. The information about him purchasing diazepam on the internet was not handed over

	to the mental health team however it was recorded on the paramedic form that was sent with the referral. The mental health practitioner assessed Mr Grady as low risk of self-harm and the incident was attributed to an impulsive act undertaken whilst intoxicated. Mr Grady's mother, whom he lived with, was not contacted as part of the assessment. The mental health practitioner was under the impression that Mr Grady was receiving input from Alcohol services and no referral was made. Mr Grady was discharged home. Mr Grady was found deceased in his bed on the morning of 26 February 2019. He died as a result of multiple drug toxicity. The drugs included prescribed and non-prescribed medication (including diazepam) and illicit drugs. Whilst the quantities of each drug found in his system would not in isolation have caused toxicity, the combined effect led to respiratory depression and death. Whilst Mr Grady was in a highly distressed state during the week-end of his death, the evidence does not meet the standard to find that he intended the consequences of his actions.
5	**<u>CORONER'S CONCERNS</u>** 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:- I heard that Mr Grady's alcohol detoxification programme in January 2018 involved two appointments with his GP during which prescriptions for a seven day course of Chlordiazepoxide were issued. The GP was unaware that Alex was using any type of drugs. Given Mr Grady's history of dependency on alcohol and benzodiazepines, a referral into the Drug and Alcohol service would have allowed for specialised support at this time of increased vulnerability. My concern is that if detoxification programmes are provided solely by the GP, adequate support is put in place. If a decision is made to manage the detoxification process within the GP practice, follow up appointments should extend beyond the date of the 7 day medication course so that questions around continued use of substances can be explored. I heard evidence that the reason that the prescriptions for Chlordiazepoxide were not referred to in the two reports prepared by the GP for the purpose of this inquest was because of a 'glitch' in the computer system which meant that it was not included in the list of medications listed on the first screen of the patient's records. My concern is that a complete list of all current and recent prescriptions should be readily accessible to GPs and other healthcare practitioners working within the practice.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 **13th January 2019**. I, the Area 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:-

	Elizabeth Grady High Level Pennine Care NHS Foundation Trust Pennine Acute NHS Foundation Trust Greater Manchester Police 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 from. 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: 18 November 2019. Signed: