IN THE WEST YORKSHIRE WESTERN CORONER'S COURT
IN THE MATTER OF:

The Inquests Touching the Death of Ricky Barcock
A Regulation Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: **Oasis Recovery Communities – 21A Bolling Road, Bradford, West Yorkshire** **Treatment Direct Ltd – 38-40 Bridge Street, Runcorn, Cheshire.** **CQC**
1	**CORONER** Martin Fleming HM Senior Coroner for West Yorkshire Western
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 20 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 20/11/18 I opened an inquest into the death of **Ricky Barcock** who, at the date of her death was aged 24 years old. The inquest was resumed and concluded on 12/7/10 I found that the cause of death to be: - 1a Morphine Toxicity II Methadone and Diazepam Use I arrived at a narrative conclusion as follows: On 6/9/18 Ricky Barcock, who had a known history of drug misuse was admitted to Oasis Recovery Communities, 21A Bolling road, Bradford, for detoxification and rehabilitation. Subsequently on 7/9/18, he was found to have died in his room after sleeping for several hours. At post mortem his blood was found to contain therapeutic levels of his prescribed methadone (0.38 ug/ml) and diazepam (0.58 ug/mlO) along with cocaine (0.18 ug/ml) and fatal quantities of morphine (1.04 ug/ml). It is found more likely than not that when he voluntarily took the morphine

	he misjudged its toxic9ity with fatal unintended consequences, but it remains unclear whether, had he been physically roused by staff during his sleep, it would have made any difference to the outcome.
4	**CIRCUMSTANCES OF THE DEATH** On 6/9/18, Ricky Barcock, who had a known history of drug misuse was admitted to Oasis Recovery Communities, 21A Bolling Road, Bradford for detoxification and rehabilitation. During the early morning of 7/9/18 Ricky was experiencing significant withdrawal symptoms such that it plrompted the nurse Cuthbert to report the matter to [redacted], who increased the dosage of his prescribed diazepam, which appears to have helped settle him. Thereafter between 9.30am and 12pm Ricky took part in the mornings timetabled activities, took his medications and had lunch, before returning to his room. Throughout the afternoon when he was looked in on by staff he was seen to be sleeping, but when checks were made to rouse him at 10.24pm he was unresponsive. This prompted immediate attempts to resuscitate him, but upon the attendance of paramedics he was found to have died. At post mortem in addition to therapeutic levels of prescribed methadone and diazepam, he was found to have used cocaine and fatal quantities of morphine, and the cause of death was identified by the pathologist as Morphine Toxicity. Although the source of the drugs remains unclear, evidence was heard to suggest that unknown to staff, it was on the premises. During the inquest I heard oral evidence from [redacted], Oasis Manager, who provided an overview of Ricky's admission and although there was nothing to suggest a medical emergency or worrying concerns about Ricky, it was accepted that in hindsight the systems for making checks on residents should be modified to extend to regular and physical checks. At the conclusion of the inquest, I invited [redacted] to submit revised protocols for client wellbeing checks received on 2/8/19, and after consideration it is my view that this regulation 28 letter is appropriate.
5	**CORONER'S CONCERNS** The **MATTER OF CONCERN** is as follows: - • To further review the client wellbeing checks protocol of September 2018 in order to consider the appropriateness of

	making physical checks and rousing client's when necessary in order to check on their wellbeing
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that Oasis Recovery Communities and Treatment Direct, has the power to take such action. In the circumstances it is my statutory duty to report to you.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to: • [redacted] - uncle • Bradford MBC • CQC • Chief Coroner
9	**DATED this 21/9/19**