Regulation 28: REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 [redacted], Manager, Free the Way, 37 Church Street, Seaham, County Durham, SR7 7EJ

1 CORONER

I am Crispin OLIVER, Assistant Coroner for the area of County Durham and Darlington

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 Third June 2021 I commenced an investigation into the death of Philip Anthony ELLIS aged 43. The investigation concluded at the end of the inquest on Tenth November 2021. The conclusion of the inquest was Narrative Conclusion - Accidental drugs related death.:

I a Respiratory Failure

I b Complications of Multiple Drug Toxicity

I c

II

4 CIRCUMSTANCES OF THE DEATH

Died on 28 May 2021 at 13 Glebe Terrace, Easington, at 20:41. Phil had been admitted to a drugs rehabilitation service on 26 May 2021. In breach of the supervision rules for service users he was able to leave the service premises unsupervised and obtain drugs, which he brought into the service premises. He self administered them on the premises, where he died. Specifically, the evidence heard at the Inquest confirmed that Phil Ellis had been able to access his home unsupervised whilst collecting clothing on 28th May. Furthermore, on a separate occasion he had been able to leave the service premises unsupervised to go into the community and meet people. On either or both occasions he could have, and probably did, obtain the drugs and drug paraphernalia implicated in his death.

5 CORONER'S CONCERNS

The MATTERS OF CONCERN are as follows: (brief summary of matters of concern)

That the deceased was able to leave the service premises unsupervised and obtain drugs in breach of the services own rules. The evidence at the Inquest indicated that there had not been a serious incident review undertaken by Free the Way into the failures of supervision in this case.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 05 January 2022. 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.

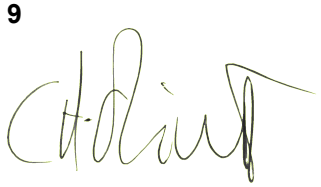
8 COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted],

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



Crispin OLIVER
Assistant Coroner for
County Durham and Darlington
Dated: 10 November 2021