REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Mr Jeremy Alston, Chief Executive of Next Stage, Comtech House, 28 Manchester Road, Westhoughton, Bolton, BL5 3QJ **2.** Mr Simon Barber, Chief Executive of 5 Boroughs Partnership NHS Foundation Trust, Hollins Park House, Hollins Lane, Winwick, Warrington
1	**CORONER** I am Rachael Clare Griffin, Assistant Coroner, for the Coroner Area of Manchester West
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 23rd March 2016 I commenced an investigation into the death of Lee Francis Grimes, born on the 12th September 1975. The investigation concluded at the end of the Inquest on the 13th July 2016. The Medical Cause of Death was: 1a Acute Left Ventricular Failure 1b Cocaine Induced Cardiac Ischaemia The conclusion of the Inquest was Drug Related Death.
4	**CIRCUMSTANCES OF THE DEATH** On the 21st March 2016 the deceased, who was known to misuse Cocaine, was found in a collapsed and unresponsive condition in the bedroom at his home address at 8 Avondale Street, Standish, Wigan.
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: 1. During the inquest evidence was heard that:

i. Mr Grimes suffered with schizophrenia and was under the care of the Mental Health Services. Since 2004 he had been supported in the community by support workers from Next Stage which is a home health care service. They provided assistance to Mr Grimes on a daily basis, Monday to Friday. They would attend at his home address to assist him with basic activities and monitor his mental health. If there was a deterioration in his mental health they would contact the appropriate service to ensure Mr Grimes was assessed and provided with treatment as required.

ii. On Thursday 17th March 2016 a support worker attended upon Mr Grimes and noted that he was not himself. At that time, he disclosed to her that he had taken an excessive dose of his prescribed medication. A note was made of this disclosure but no action was taken following that information being provided to the support worker.

iii. The following day, Friday 18th March, another support worker, [redacted] attended upon Mr Grimes at about 10am, when he again disclosed that he had taken an overdose of his Procyclidine medication, explaining he had taken 12 tablets. At that time, [redacted] called Wigan Recovery North, the Community Mental Health Team which is governed by 5 Borough Partnerships NHS Foundation Trust, to speak to a Community Psychiatric Nurse (CPN), to report that Mr Grimes had taken excessive medication. A message was left on an answerphone by [redacted] requesting a call back and explaining that Mr Grimes had taken an overdose of medication. No return call was made to [redacted] nor was any further call made to Wigan Recovery North by employees at Next Stage to follow up the initial message left. Mr Grimes did not have any contact with anyone after Friday 18th March and was found dead at his home address on Monday 21st March.

iv. Evidence was given that if a service user discloses they have taken an overdose of medication to a support worker from Next Stage, that support worker should then speak to a CPN from Wigan Recovery North, if the disclosure is made during their operating hours of 9am to 5pm Monday to Friday. If the disclosure is made out of office hours, Next Stage have an out of hours system where action is taken by the person contacted out of hours to further investigate or manage the service user's wellbeing.

v. Evidence was given by [redacted] that there is training that Next Stage offer in respect of how to deal with a report of an overdose by a service user, and other situations that may arise when providing support to a service user, but that he had not had any training in 3 years as his workload did not allow him to undertake training. [redacted] confirmed that he felt he, and the other employees from Next Stage, would benefit from further training, which could prevent a future death.

	2. I have concerns with regard to the following: i. That no action was taken by an employee of Next Stage following Mr Grimes' disclosure of an overdose of medication on Thursday the 17th March. I have further concern that when action was taken on the Friday 18th March, a message was left for the Community Mental Health Team which was not followed up by Next Stage, or answered and actioned by the Community Mental Health Team. Although Mr Grimes' death was not as a result of an overdose, he did not receive any assessment, or treatment, in respect of the overdose he disclosed. In view of the fact that there was no contact from the Next Stage or the Community Mental Health team over the weekend, he was vulnerable to taking a further overdose of medication. ii. I have concerns that if this situation occurs in the future, another person could die. In view of that I would ask that the current policies and procedures in place at Next Stage to deal with the disclosure of an overdose of medication by a service user, are reviewed, and cascaded down to all employees. I would also request that a review is carried out by 5 Boroughs Partnership of the policies and procedures in place regarding the processing of referrals to Wigan Recovery North given the fact that the message left by [redacted] on the Friday morning was never acted upon, as if this were to happen again in the future I believe there could be a further death.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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, 20th September 2016. 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) [redacted], Mr Grimes' mother on behalf of the family 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** **26th July 2016**	**Signed** **Rachael C Griffin**