Regulation 28: Prevention of Future Deaths report
Michelle Susan Turner (died 01/06/19)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • [redacted], Chief Operating Officer for the Fylde and Wyre Clinical Commissioning Group and of the Blackpool Clinical Commissioning Group, Blackpool Stadium, Seasiders Way, Blackpool, FY1 6JX.
1	**CORONER** I am: Tim Holloway Assistant Coroner for Blackpool & Fylde Municipal Buildings, PO Box 1066, Corporation Street, Blackpool, FY1 1GB
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 5th June 2019 an investigation was commenced into the death of Michelle Susan Turner. The inquest which formed part of that investigation was opened on 17th July 2019 and the investigation concluded at the end of the inquest which was heard over a period of 3 days from 12th October 2020 to 14th October 2020 inclusive. The conclusion of the inquest as to the medical cause of death was as follows: "1a. Multidrug toxicity" I reached the following conclusion as to Michelle Turner's death: "Drug related death"
4	**CIRCUMSTANCES OF THE DEATH** My findings as to how, when and where Michelle Turner came by her death were as follows: "Police attended the address of Michelle Susan Turner at [redacted] Road, Freckleton on Saturday 1st June 2019 where she was found slumped and unresponsive on the floor of an upstairs bedroom. The Deceased's death was confirmed at the scene. Michelle Susan Turner died at her home at [redacted] Road, Freckleton on Saturday 1st June 2019, her death having been caused by her use of heroin, cocaine and tramadol in the period leading up to her death. Each of those drugs made a more than minimal, negligible or trivial contribution to her death in combination with the others."
5	<u>**CORONER'S CONCERNS**</u> During the course of the inquest the evidence revealed a matter 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 **MATTER OF CONCERN** is as follows – I heard evidence and found that Michelle Turner had the support of her care coordinator and of her peer support worker and that she appeared to have built very positive relationships with each of them. I also heard evidence that: • The Clinical Commissioning Group holds the responsibility for the funding of peer support workers; • Peer support workers provide a variety of forms of support to service users, including assistance with connecting with drug services, support in managing their day, support in leaving the house and support in engaging in activity and that, very significantly, peer support workers have or may have "lived experience" of alcohol and/or substance misuse; • This is an "invaluable" resource and, despite the circumstances of her death, Michelle Turner had felt inspired by her peer support worker; • There is a possibility that funding for peer support workers will be lost in March 2021. The concern that arises in these circumstances is that the service provided by peer support workers, which may be essential to those with mental health conditions and/or with alcohol and/or substance misuse problems and which is provided by those who, amongst service providers, may have the unique perspective of having "lived experience" of such problems, may be lost.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the Clinical Commissioning Group concerned has the power to take such action. This report should not be read, in any sense, as implying any criticism and decisions such as those in question are, ultimately, a matter for the Clinical Commissioning Group.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 12th January 2021. 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: • **THE FAMILY OF MICHELLE TURNER** • **LANCASHIRE AND SOUTH CUMBRIA NHS FOUNDATION TRUST** • **DR** [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	Date: 18/11/2020 Signature *TRHolloway* Tim Holloway Assistant Coroner, Blackpool & Fylde