




REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1. The Chief Executive, Bury Metropolitan Borough Council</p>
1	<p>CORONER</p> <p>I am Ms L J Hashmi, Area Coroner for the Coroner area of Manchester North</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On the 10th June 2014 I commenced an investigation into the death of Anthony Maurice Huggan</p>
4	<p>CIRCUMSTANCES OF DEATH</p> <p>Mr Huggan had a long standing drug problem. Having served a short sentence of imprisonment, he was released from custody on the 2nd June 2014.</p> <p>The same day, he took an accidental overdose of opiates resulting in his admission to hospital. At the point of admission, he was gravely ill. Urgent medical treatment was initiated and he was admitted to HDU with a Naloxone infusion.</p> <p>On the 3rd June 2014 the deceased decided to take self-discharge, against medical advice. He was assessed and deemed to have mental capacity to make that decision. He was advised of the potentially very serious consequences (including death) but nonetheless took self-discharge. A telephone call was made (it is believed by the hospital's Pharmacist) to the community drugs team to advise them of Mr Huggan's actions, so as to ensure safe follow up in the community.</p> <p>Post discharge, Mr Huggan took excessive amounts of prescribed and illicit substances.</p> <p>The voicemail message relating to the deceased's self-discharge was picked up from the CDT answerphone on the 4th June 2014.</p> <p>The housing support officers attended the deceased's address the same day and were met by his friend who was concerned about Mr Huggan's health (he had been up most of the night checking upon him). Mr Huggan was subsequently found deceased in bed.</p> <p>Post mortem examination and toxicological analysis showed that the deceased died as a result of combined drugs toxicity (Pregablin, Morphine and Methadone).</p> <p>During the course of the evidence, it transpired that the Community Drugs Team are commissioned to provide care to service users between the hours of 09:00-17:00, Monday to Friday. There is no 'out of hours' provision. In the event of an emergency, service users are told to contact A & E, their GP or the Police.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p>

	<p>The MATTERS OF CONCERN are as follows:-</p> <ol style="list-style-type: none"> 1. The lack of a suitable out of hours service, resulting in an undue burden being placed upon the emergency services and the NHS (none of whom are best placed to deal with and support those with drug addiction problems). 2. Where a patient takes self-discharge following a life threatening drugs overdose, concerns arise around the timeliness of follow up/welfare checks, given the limitations of the service commissioned by the Local Authority.
6	<p>ACTION SHOULD BE TAKEN</p> <p>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.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely 21st January 2015. I, the Coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely:-</p> <ul style="list-style-type: none"> - Family of the deceased - Legal representatives of the acute Trust - CDT Bury <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>Date: 26.11.2014 .</p> <p>Signed: </p>