## **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** RE: ALEXANDER GEORGE BALL Deceased THIS REPORT IS BEING SENT TO: - Cumbria Partnership NHS Foundation Trust CORONER I am David Llewelyn Roberts, senior coroner, for the coroner area of Cumbria. 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. INVESTIGATION and INQUEST 3 On 26<sup>th</sup> February 2014 I commenced an investigation into the death of Alexander George Ball, Age - 50. The investigation concluded at the end of the inquest on the 29th January 2015. CIRCUMSTANCES OF THE DEATH 4 (3) On the night of the 20th February 2014 the deceased was found unresponsive lying on his bed at his home at 5 The Crescent, Thornhill. He was on a methadone programme and prescribed antidepressants. He also accessed illicit drugs including diazepam, phenazepam, heroin and cannabis in the days before his death. He saw a Psychiatrist on the 7th January, his General Practitioner on the 11th February and his Drugs Counsellor on the 20th February. He was on a waiting list for the allocation of a Care Coordinator. He died as a result of ingestion of both prescription and illicit drugs. This followed a deliberate overdose of street diazepam on about the 1st February and recommencing the use of heroin on about the 16th February. There is no evidence that the ingestion of the drugs which resulted in his death was done with the intention of ending his life. On the balance of probabilities the appointment of a Care Co-ordinator would have aided communication between those caring for him, and that an earlier rereferral to Mental Health Services may have resulted in benefits to his mental wellbeing. 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. -There was a lack of communication between the Partnership Trust and other agencies. The position was exacerbated by the absence of a dedicated Care Co-ordinator. 6 ACTION SHOULD BE TAKEN Cumbria Partnership Foundation Trust to take action and engage with its health partners in learning lessons from the death of Mr. Ball and drawing conclusions on how services might be improved to secure better outcomes for patients presenting with complex 7 YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by the 16th April 2015. 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. COPIES and PUBLICATION I have sent a copy of my report to the Chief Coroner and to the following Interested (Parents) (Sister) I have also sent it to (GP) 2) Ann Farrar - Chief Executive - North Cumbria University Hospitals NHS Trust 3) Bev Humphrey - Chief Executive - Greater Manchester West Mental Health 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 19th February 2015 [SIGNED BY CORONER]