# REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

| | |
|---|---|
| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**Medical Director of the Greater Manchester NHS Area Team**<br>**Chief Executive Greater Manchester West Mental Health NHS Foundation Trust**<br>**Practice Manager Bodmin Road Health Centre** |
| 1 | **CORONER**<br><br>I am Joanne Kearsley Area Coroner for Manchester South |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On the 3rd December 2015 I concluded the Inquest into the death of Jake Robinson date of birth 03.03.1992 who died on the 23.08.2015 at his home [redacted]<br>The cause of death was 1a) Hanging 2) Illicit Drug Use<br><br>I recorded that the deceased died at his home address. At the time of his death he was using illicit drugs and "legal highs" which were purchased over the internet, which on balance contributed to his state of mind. I returned a conclusion that the deceased had taken his own life. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>The Court heard evidence that Jake was a young man for whom his family had had no concerns until approximately 12 months prior to his death. Following the death of a family member in 2013 there had been a deterioration in Jake's behaviour and he had also lost a lot of weight. In January 2015 Jake was seen by mental health services (RAID) and a referral was made to Phoenix Futures – a young person drug and alcohol service. He developed a good relationship with his Substance Misuse worker from this service. It was known that Jake was buying significant illicit benzodiazepine over the internet. In 2015 Jake also presented on three occasions to the Accident & Emergency Department, three of these occasions were due to self harm attempts and suicidal thoughts including on two occasions in April and twice on the 9th and 17th July 2015 when he had tied a ligature around his neck and taken an overdose.<br><br>An attendance in March 2015 was due to a seizure. |

| | |
|---|---|
| | On each occasion it was felt that his drug use was the primary difficulty and he was referred back to the substance misuse services.<br><br>Although Phoenix Futures were the drug service engaged with Jake they have no ability to prescribe medication so a referral was made to Trafford AIM a Community Drugs and Alcohol Service.<br><br>Due to the seizure in March Jake had required further investigations, this meant that he was not able to be prescribed Diazepam (which it was recognised he required in order to be detoxed from his illicit benzodiazepine use). He had received a short course from his GP in 20th march until the 29th April.<br><br>A referral had been made for Jake to be seen by the Community Mental Health Team but the appointment made was at the same time on the 19th August as he had an appointment with the Trafford Aim Service. Jake was advised to rearrange his appointment with the CMHT – the Court did not hear any evidence to explain why the decision was taken to rearrange the CMHT appointment as opposed to the appointment with Trafford Aim. The appointment was rearranged for the 28th August, 5 days after Jake died. |
| 5 | **CORONER'S CONCERNS**<br><br>The concerns noted by the Court during the course of the Inquest are as follows:<br><br>1) The Court heard evidence that his GP had written to Greater Manchester West on the 23rd June 2015 ( exactly to whom this letter was addressed is not known as it was not provided in the evidence from the GP practice) indicating that Jake could be prescribed diazepam following the investigation for his seizure. There was no indication in the review by GM West as to whether this letter had been received and if not why not. However neither of the Drug Services who were involved with Jake were aware of this information and therefore he was not commenced on any benzodiazepine reduction. This issue is being brought to the attention of all the recipients of this Regulation 28 report including the Medical Director for the Greater Manchester NHS Area who will be aware of the same concern raised in a separate recent case.<br><br>2) The failure to identify the above issue as part of the review into the death of Jake Robinson is a concern as it highlights a missed opportunity to potentially learn lessons.<br><br>3) The fact that Phoenix Futures have no ability to prescribe medication to their services users was a concern. It meant that young people with substance misuse issues have to be referred to Trafford Aim, who are a service for people over the age of 26. Jake had a good relationship with Phoenix Futures but he did struggle to engage with services. |

| | |
|---|---|
| | The fact that he then had to engage with two services added to what in the Courts view was a disconnected approach to dealing with Jakes increasing difficulties.<br><br>4) There was no explanation in the review as to why the appointment clash between Trafford Aim and the Community Mental Health Team led to the appointment with the CMHT being rearranged. Particularly as Jake had made two recent serious attempts of self-harm in July 2015 and was at the very least recognised as a high risk of accidental self-harm. Given that Trafford Aim were not prescribing Jake at this time the Court had some difficulties in understanding what their role was given that he was also under Phoenix Futures for his substance misuse. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. It should be noted that both of the medical practices involved in this particular case had themselves noted flaws in the systems and taken steps to address some of the issues themselves, however the findings of the Court highlight an issue which may impact on medical practices across Manchester. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 11.02.16 I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely, **the family of Mr Robinson**<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **09.12.2015** **Joanne Kearsley Area Coroner** |