REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive** **Michael Scott** **Norfolk & Suffolk NHS Foundation Trust** **Trust Management** **1st Floor Admin** **Hellesdon Hospital** **Drayton High Road** **Hellesdon** **Norwich, NR6 5BE**
1	**CORONER** I am JACQUELINE LAKE, Senior Coroner, for the coroner area of NORFOLK
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 4 July 2016 I commenced an investigation into the death of DAVID SEAN READ, AGE 29 years. The investigation concluded at the end of the inquest on 23 January 2017. The medical cause of death is 1a) Mixed Drug and Alcohol Toxicity which includes Heroin Toxicity and the conclusion of the inquest was Drug and Alcohol Related
4	**CIRCUMSTANCES OF THE DEATH** Mr Read lived at Herring House Trust, 51 St Nicholas Road, Great Yarmouth, Norfolk. On 1 July 2016 Mr Read collapsed after injecting heroin. He was taken to James Paget University Hospital by paramedics where he died on 3 July 2016.

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) Mr Read was referred to the Crisis and Resolution Home Treatment Team by his GP on 24 February 2016 as an urgent referral and was duly seen that evening when it was decided there should be input from the Community Mental Health Team. (2) On 25 February 2016 Mr Read was referred by a Social Worker at Herring House, where he was residing, to the Community Mental Health Team and he was given an appointment for 21 March 2016, under 4 weeks from the date of the initial referral. (3) This appointment was cancelled by Mr Read (no reason is recorded for the cancellation but Mr Read did start alcohol detoxification on this date) and his name was added to the waiting list for a fresh appointment to be arranged. (4) The appointment was treated as a new referral and a new appointment date was sent out on the 18 May 2016 with a new appointment date of 14 July 2016. This is in excess of 16 weeks after the re-referral. Sadly Mr Read died in the meantime.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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, namely by 10 April 2017 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: [redacted] (mother). 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	**8 February 2017** ..... **Jacqueline Lake** **Senior Coroner for Norfolk**