Grahame Antony Short
Senior Coroner for Southampton & New Forest

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Solent NHS Trust**
1	**CORONER** I am Grahame Antony Short, Senior Coroner for Southampton & New Forest
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 29/07/2016 I commenced an investigation into the death of Grant David Burns, 35. The investigation concluded at the end of the inquest on 30 January 2017. The conclusion of the inquest was this was a Drug related death.
4	**CIRCUMSTANCES OF THE DEATH** At an unknown time between 20.05 on 22 July and 15.15 on 23 July 2016 whilst alone in room [redacted] at The Booth Centre 57 Oxford Street Southampton Grant Burns took an excess quantity of methadone, heroin and Alprazolam. He died due to Morphine, Methadone and Alprazolam Toxicity. Grant Burns had a dual diagnosis of paranoid schizophrenia and drug and alcohol abuse.
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) The death was the subject of Root Cause Analysis report by Southern Health NHS Foundation Trust who provided the Early Intervention in Psychosis Service (EIPS) for the deceased, which found there was a lack of co-operative working between the EIPS and the Substance Misuse Service based at New Road Southampton provided by Solent NHS Trust (2) The Southern Health report highlighted that their report was incomplete because there was no input from the key worker at New Road despite best efforts (3) There was a lack of communication between partner agencies

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6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Solent NHS Trust 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 14 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: Southern Health NHS Foundation Trust and [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	Dated 23 February 2017 Signature_____ Senior Coroner for Southampton & New Forest

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