



REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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| | <p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1. Department of Health, London</p> |
| 1 | <p>CORONER</p> <p>I am Ms L 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 16th June 2017 I commenced an investigation into the death of Timothy John Smedley.</p> |
| 4 | <p>CIRCUMSTANCES OF DEATH</p> <p>Against a backdrop of fluctuating emotional vulnerability, enduring alcohol addiction and depression, the deceased was found at around 17:20 hours on the 7th June 2017 in a shallow waterway at the foot of Rakewood Viaduct. He had sustained catastrophic injuries. The fact of his death was confirmed by Paramedics later the same day.</p> <p>The conclusion that I reached was suicide.</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 (joint) access to NHS records by 'out of hours' services such as GPs, Urgent Care Centres etc. resulting in unsafe, fragmentation of care.2. The difficulties that patients with known alcohol addiction face in accessing appropriate and timely mental health services, alongside an apparent lack of awareness surrounding the complexities their presentation. |
| 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> |

