REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Chief Executive of Pennine Care, the Chief Executive of Tameside General Hospital, the Chief Executive of Tameside Clinical Commissioning Group, the Secretary of State for Health and the Chief Executive of NHS England
1	CORONER I am Alison Mutch ,Senior Coroner, for the Coroner Area of South Manchester
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 16th December 2016 I commenced an investigation into the death of Adrian Jennings .The investigation concluded on the 22nd March 2018 and the conclusion was a narrative one of Drug-related death contributed to by a failure to put in place and communicate an effective support plan following discharge from hospital. The medical cause of death was drug toxicity
4	**CIRCUMSTANCES OF THE DEATH** Adrian Jennings had a history of mental health issues and attempts at self-harm. He was admitted to Taylor Ward following a presentation at Tameside General Hospital in October 2016. During his stay on Taylor Ward he and his family expressed concerns in relation to support in the community and the consequences of a lack of support. In particular that he would use drugs to cope if not supported in the community. Following his discharge the Home Treatment Team (HTT) visited him on 1st December 2016 and 5th December 2016. On 5th December 2016 he was told that 12th December was likely to be the last visit. There was no communication of the support he would receive following that visit. Attempts on 9th December 2016 by his family to

	understand the support plan were unsuccessful. Communication between the Pennine Care Teams involved was poor and hampered by the use of different I.T systems. There was a failure to effectively communicate with Adrian Jennings and his family. It is probable that the lack of effective support and communication in relation to the support plan contributed to his death. On the 9th December 2016 and in the absence of a clear support plan when attempts to support to obtain any clear information had been unsuccessful Adrian Jennings took a cocktail of drugs and alcohol. He was found by Greater Manchester Police outside Costcutters at 02:40 on 10th December 2016. Concerned that he had taken an overdose and about his safety he was taken by Greater Manchester police officers to Tameside General Hospital. At booking in there was a failure to record key information by the staff. This meant there was a missed opportunity to record how high risk he presented. He left Tameside General Hospital before triage. His absence was not reported to Greater Manchester Police because the policy had a gap which meant that high risk absconding between booking in and triage were not reportable. It is possible that this contributed to his death. Adrian Jennings subsequently went to a friend's address on the morning of 10th December 2016 where he was seen to go into a deep sleep. That evening he was seen to be no longer breathing. He was taken by ambulance to Tameside General Hospital and pronounced dead on 10th December 2016. Post mortem toxicology showed a fatal cocktail of drugs in his system. It is unclear at precisely what point all the drugs were ingested.
5	<u>CORONER'S CONCERNS</u> 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 inquest heard evidence that the Mental Health Trust had not introduced one IT system across the Trust, which impacted on information sharing between professionals involved in his care; 2.there was no clear system for the primary and secondary mental health services of the mental health trust ,Pennine Care, to develop a joined up discharge plan following a stay on the mental health ward; 3. a need for a type of mental health support service had been identified by the mental health trust Pennine Care but it could not be delivered because the Trust had not been commissioned to deliver the service; and 4. Tameside Hospital cannot change their electronic booking in/triage system to allow them to include drop down boxes for key information such as the fact that Police Officers have brought an individual to the Hospital because it is a national IT system. Any trust operating the Lorenzo system will struggle to capture this

	information at booking in
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you 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 14th June 2018. 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 namely [redacted], Mother of the deceased, who may find it useful or of interest. 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	Alison Mutch OBE HM Senior Coroner 19/04/2018