REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted]** **Chief Officer** **NHS Kernow Clinical Commissioning Group, St Austell, Cornwall** **2. Philip Confue** **Chief Executive** **Cornwall Partnership NHS Foundation Trust**
1	**CORONER** I am Guy Davies, Her Majesty's Assistant Coroner for Cornwall & the Isles of Scilly
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 27th October 2017 I commenced an investigation into the death of Marcus HANCE. The investigation concluded at the end of the inquest on 31st May 2018. The conclusion of the inquest was as follows Marcus HANCE died on 13th October 2017 at The Queens Head Inn, North Street, St Austell from the synergistic effect of a reckless overdose of illicit and therapeutic drugs, within the context of a history of drug abuse. My conclusion as to the death is that it was Drug Related.
4	**CIRCUMSTANCES OF THE DEATH** Marcus Hance was found dead at his home address from a reckless overdose of illicit and therapeutic drugs, including amphetamine and heroin. Marcus had a complex medical history which included a diagnosis of borderline personality disorder and a history of drug abuse. This was characterised as a dual diagnosis, namely a personality disorder and drug dependency.

	The evidence from the Cornwall Partnership NHS Foundation Trust (CPT) concerned the role of the Mental Health Services. This included Community Mental Health Team (CMHT) assessments which revealed a long history of mental health difficulties and a diagnosis of Borderline Personality Disorder. The CPT conclusion on a number of repeat referrals was that the drug dependency should be addressed before any mental health treatment could proceed. On the occasion that the deceased was referred to CMHT, Marcus was discharged following two instances of non-attendance at CMHT appointments. Addaction provided care and treatment from 2013 to 2017 in an attempt to deal with the drug dependency. The only real engagement was from March 2017 but was problematic and progress was not sustained. The work by Addaction did not involve any measures to address the mental health issues, but was focused upon addressing the drug abuse. Marcus continued to abuse drugs up until his death.
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) Marcus was in a position where he was getting support with his drug dependency from the drug and alcohol team but was not able to access support for the mental health issues which were associated with the drug dependency. (2) The approach to cases of dual diagnosis, that substance misuse should be addressed before any mental health treatment could proceed. (3) The discharge from CMHT on failing to attend two appointments.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action, namely (1) To review the commissioning of services to support individuals who have drug and alcohol dependency and associated complex mental health issues. (2) To review whether drug and alcohol agencies should have the support of relevant mental health professionals to address issues of dual diagnosis, and for appropriate referring pathways and assessments within these agencies to ensure the appropriate support is being provided to increase the prospects of rehabilitation. (3) A review generally of the current pathway and provision for persons

	with dual diagnosis. (4) To review whether a joint approach can be facilitated by mental health services and by drug and alcohol dependency services in cases of dual diagnosis. (5) To review the approach taken in cases of non-attendance at mental health appointments, and whether attempts to contact service users should be undertaken, or alternatively to involve the police if there are concerns for the individual's welfare.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 2nd August 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 [redacted] Marcus' mother. I have also sent it to the following persons who may find it useful or of interest. [redacted], Operations Director, Addaction. [redacted], Co-coordinator, Cornwall drug action team. 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	**7th June 2018** **Guy Davies**