

## REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: The Chief Executive of Pennine Care NHS Foundation Trust, 225 Old St, Ashton-under-Lyne OL6 7SR .

### CORONER

I am Chris Morris, Area Coroner for Manchester South.

### 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>

### INVESTIGATION and INQUEST

On 26<sup>th</sup> April 2018, Rachel Galloway, Assistant Coroner for Manchester South, opened the inquest into the death of Conor Crutchley who died at his home address on 14<sup>th</sup> January 2018 at the age of 19 years.

The investigation concluded at the end of the inquest which was heard on 9<sup>th</sup> January 2019. The inquest concluded that Mr Crutchley's death was drug-related.

### CIRCUMSTANCES OF THE DEATH

Mr Crutchley had a significant history of mental health problems, and also had significant periods when he misused drugs.

Following an attendance at hospital in summer 2017, Mr Crutchley was referred to Pennine Care NHS Foundation Trust's Early Intervention Team. He was diagnosed with schizoaffective disorder and prescribed medication.

Over the course of Mr Crutchley's care and treatment, a family member disclosed to a member of Trust staff that she had become concerned he had started using street drugs again.

When this was raised with Mr Crutchley, he denied it. Staff signposted Mr Crutchley to local drug and alcohol services, should he wish to avail himself of them.

Mr Crutchley was subsequently found dead at the home he shared with his parents. A post mortem examination concluded he died as a consequence of the combined toxic effects of cocaine and alprazolam.

## 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. –

In the course of the inquest, evidence was heard to the effect that a significant proportion of the Early Intervention Team's patients have a dual-diagnosis of substance abuse and mental health problems.

It is a matter of concern that the Early Intervention Team does not include specialist drug and alcohol workers amongst its number. Such professionals work for external providers and interaction with service users appear to be dependent on self-referral.

Whilst the witness who gave evidence on behalf of the trust was unable to provide details of current waiting times, it is a matter of additional concern that at times significant wait can be encountered by service-users referred for talking therapies. The evidence before the court suggested such delays were often associated with difficulties recruiting and retaining appropriately qualified therapists.

## ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

## YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 25<sup>th</sup> March 2019. I, the coroner, may extend the period.

## COPIES and PUBLICATION

I have sent a copy of my report to Mr Crutchley's parents, and to the Chief Coroner.

I have sent a copy of my report to the Accountable Officer of Tameside Clinical Commissioning Group, 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.



Signature: Chris Morris HM Area Coroner, Manchester South.  
HM Area Coroner  
28/01/2019