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 NHS Foundation Trust
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 20th April 2018 I commenced an investigation into the death of Matthew Gerard Craven. The investigation concluded on 1st November 2018 and the conclusion was one of **Accidental Death**. The medical cause of death was **1a) Pregabalin Toxicity 2) Codeine and Chlordiazepoxide use, Pulmonary Embolism due to Deep Venous Thrombosis**
4	Matthew Gerard Craven was prescribed pregabalin for his anxiety. Following his discharge from Stepping Hill Hospital on 17th April 2018, he consumed pregabalin in excess of the prescribed amount. He had done this previously with no ill effect. On 19th April 2018, Matthew Gerard Craven was found dead at his home address, [redacted]

	[redacted] Toxicology showed that he had a fatal dose of pregabalin in his system.
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. – The inquest heard that: He had long-term anxiety. Mental Health workers assessing him had repeatedly felt he needed to be seen by a psychiatrist. The referrals were rejected by the psychiatrist. There was no challenge or escalation process within the trust to deal with the situation. A routine psychiatric out patient was offered after his mother indicated she would make a formal complaint. The inquest heard that there were no agreed target timescales for the offering of routine appointments. There had been a series of attendances at the emergency department and RAID referrals. The inquest heard that there was no documentation or rationale provided for why RAID did not refer him to a psychiatrist. On one admission to the acute hospital following an overdose, he was seen by an alcohol worker from the Mental Health Trust. There was no evidence that that worker had checked to see or understand any previous engagements with Mental Health Services. Information about that admission and encounter was not shared with wider mental health services even though they were part of the same trust.
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 17th January 2019. 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] the deceased's mother, 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** **22.11.2018**