**IN THE TRURO CORONERS COURT**

**IN THE MATTER OF THE INQUEST TOUCHING THE DEATH OF PAUL MATTHEW GILLAM**

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**(1) [redacted],**<br>**Head of Mental Health and Learning Disability commissioning**<br>**NHS Kernow**<br><br>**(2) Philip Confue**<br>**Chief Executive**<br>**Cornwall Partnership NHS Foundation Trust**<br><br>**(3) [redacted]**<br>**Joint Commissioning Manager**<br>**Cornwall & Isles of Scilly Drug and Alcohol Action Team**<br>**Cornwall Council** |
| 1 | **CORONER**<br><br>I am Guy Davies, Her Majesty's Assistant Coroner for Cornwall & the Isles of Scilly. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 14th June 2018 Cornwall Coroners commenced an investigation into the death of 47 year old Paul Matthew GILLAM. The investigation concluded at the end of the inquest on 8th February 2019.<br><br>The four questions - who, when, where and how – were answered as follows …<br><br>Paul Matthew GILLAM died on 3rd June 2018 at flat 8, 34 Downs View, BUDE, from the toxic effect of a reckless overdose of non-prescription and prescription drugs.<br><br>My conclusion as to the death is that it was a *Drug Related Death.* |

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| | The medical cause of death was established on the evidence as<br><br>1a (namely the condition directly leading to death) - Synergistic toxic effects of several central nervous system depressants.<br><br>The pathologist noted that the toxicology '*… results show the presence of morphine and methadone at potentially toxic levels… Diazepam, gabapentin and sertraline were detected at therapeutic levels. CNS depressant drugs may act synergistically to enhance their toxic effects on the cardiorespiratory system…'* |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Paul was found dead in his bed at his home address on 5th June 2018 by friends.<br><br>Paul had a previous medical history of asthma, emphysema, depression, anxiety, chronic obstructive pulmonary disease (COPD), drug and alcohol abuse, including a history of heroin abuse.<br><br>[redacted] was the last person to see Paul alive, on 3rd June 2018. Paul had spent the afternoon drinking in the gardens at Paul's home address. Paul had arrived at 1400 hours – already under the influence of drugs or drink, and was seen to consume vodka and take six pills, of unknown composition. At around 1930 hours[redacted] helped Paul back to his room, at this time Paul was having difficulties walking; [redacted]d assumed this was due to Paul's COPD.<br><br>Paul was not seen alive again after the party on Sunday 3rd June and was found deceased wearing the same clothing on Sunday, when he was last seen.<br><br>There was no evidence of any intent to end his own life or of any third party involvement. Due to Paul's lifestyle and his poor health, a combination of an overdose of drugs and his already weakened respiratory system, likely lead to him dying whilst asleep on 3rd June 2018.<br><br>Paul had been under the care of Addaction, drug and alcohol treatment team since his arrival in Cornwall in 2012. There had been a number of referrals to the community mental health team (CMHT).<br><br>The evidence indicated that the concerns for Paul's mental health were ongoing throughout treatment. Paul continued to experience episodes of paranoia, low mood and anxiety until his death.<br><br>The evidence revealed issues in communication between Addaction and CMHT.<br><br>It was unclear to Addaction why Paul's initial support was ended or why Addaction did not receive further feedback from the further referral in July 2017, other than |

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| | being advised in August 2017 that Paul was awaiting allocation of a CPN. Addaction were not aware of the repeated failures by Paul to attend appointments with CMHT or the recommendations made by CMHT for Paul to engage in voluntary work. Addaction gave evidence that if they had known of the non-attendance record that steps would have been taken to ensure Paul's attendance. Addaction were aware that non-attendance at CMHT may lead to discharge.<br><br>The evidence suggested that Addaction were unaware of the full extent of the work undertaken by CMHT or of Paul's subsequent lack of engagement with CMHT.<br><br>The court heard that the appropriate policies and service level agreement (SLA) had been developed but that the issue lay with communication between Addaction and CMHT, and the implementation of the policies and the delivery plan concerning the relationship between Addaction and CMHT. The court heard the working relationship between Addaction and CMHT could be improved.<br><br>The court did not seek to resolve the issues between CMHT and Addaction. The reasons for the communication breakdown were not directly relevant to the statutory questions that had to be answered by the court. Nevertheless, the issue of the communication breakdown is relevant to the concern of the court to prevent future deaths. There was no requirement to pursue an enquiry in order to seek to unravel the reasons for the breakdown and attribute blame. That is not the role of the Coroners Court, and in addition such an enquiry was not necessary to fulfil the obligations of the Coroners Court. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows -<br><br>(1) The operation of the Cornwall dual diagnosis policy and the interface between Addaction and CMHT.<br><br>(2) The development and implementation of the delivery plan in relation to the existing service level agreement between CMHT and Addaction.<br><br>(3) The working relationship between CMHT and Addaction. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action. |

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| | (1) To review the operation of the Cornwall dual diagnosis policy and the interface between Addaction and CMHT.<br><br>(2) To review the development and implementation of the delivery plan concerning the relationship between CMHT and Addaction.<br><br>(3) To consider how best to encourage a closer working relationship between CMHT and Addaction.<br><br>I would be pleased to hear from you in relation to these concerns. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 8th April 2019. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons;<br><br>[redacted] (father)<br><br>I have also sent it to the following who may find it useful or of interest;<br><br>[redacted], Addaction Team Leader<br>[redacted], Drug Related Death Prevention Coordinator<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **[DATE]** **[HM CORONER]**<br>**11th February 2019** **Guy Davies** |