

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO: Secretary of State for Health</p>
1	<p>CORONER</p> <p>I am Alison Mutch , Senior Coroner, for the Coroner Area of Greater Manchester South</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 22nd July 2019, I commenced an investigation into the death of Shaun Lea Turner. The investigation concluded on the 31st January 2020 and the conclusion was one of Suicide. The medical cause of death was 1a) Drug toxicity on a background of bronchopneumonia</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>On 20th July Shaun Lea Turner was found unresponsive at his home address [REDACTED] Dukinfield. Police investigations found there were no suspicious circumstances or evidence of 3rd party involvement. A number of notes addressed to family members were recovered. Toxicology showed that he had ingested a fatal amount of codeine.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>During the course of the inquest, evidence was given by Mr Turner's family that whilst they accepted that there had been attempted contact of him by mental health services he was worried about how long it would take him to be able to access appropriate mental health services and receive support. He was aware through previous contact with Mental Health services that there could be delays and when he missed a call from them, the impact of that in relation to accessing mental health services preyed on his mind.</p>

6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 28th April 2020. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely [REDACTED] wife of the deceased, who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>Alison Mutch OBE HM Senior Coroner 03.03.2020</p> 