Kally Cheema LLB | Senior Coroner| Cumbria

Fairfield, Station Road, Cockermouth, Cumbria CA13 9PT

23 November 2021

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: . Chief executive, Greater Manchester Mental Health NHS Foundation Trust, Trust Headquarters, Bury New Road, Prestwich, Manchester M25 3BL

Director of services -northwest region, Humankind, Inspiration House, Unit 22 Bowburn North Industrial Estate, Durham DH6 5PF

1	**CORONER** I am Dr Nicholas Shaw, Assistant Coroner for Cumbria.
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 26 February 2021 I commenced an investigation into the death of Darrell Lee DEVLIN aged 33. The investigation concluded at an inquest on 18th November 2021 . The short form conclusion of the inquest was that of a Drug Related Death. The medical cause of death being given as: 1a Bronchopneumonia and drug use ( )
4	**CIRCUMSTANCES OF THE DEATH. The record of inquest read as follows: Darrell Lee Devlin died at his home on 23rd February 2021. He had been unwell for a few weeks with a chest infection and was also under the care of the local drug and alcohol service provider receiving a methadone prescription. Postmortem examination revealed active bronchopneumonia and an extremely high level of Flubromazolam in his bloodstream. The combination of these two factors caused his death.**
5	**<u>CORONER'S CONCERNS</u>** 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. -

[BRIEF SUMMARY OF MATTERS OF CONCERN]

(1) Darrell first came into contact with Unity (the drug and alcohol service that your trust was contracted to provide for Cumbria) in 2015. and his final episode of care began on 30th January 2020 when he self referred to ask for treatment for daily heroin use. At the time of his death he was receiving a daily dose of [redacted] Methadone supplied every week. Evidence heard at the inquest covered the final 7 months of this treatment episode, during this period I heard of 6 telephone contacts, the last just 18 days before Darrell died, however he was never seen in person and never tested for drug use.

(2) Apart from admitting to a single bag of heroin on 1 occasion Darrell consistently told his drug workers that he was abstinent from illicit drugs or alcohol and was well maintained on his daily dose of methadone. The forensic toxicology report (of which I attach a copy for your information) however indicates he was almost certainly not truthful. I am concerned that reliance on remote contacts and lack of testing make it very difficult for drug workers to accurately assess and support their clients, and put the clients at risk of harm or death due to excessive dosage or polydrug exposure on top of their regular medication, as in this case. I am aware that face to face appointments were avoided where possible due to the Covid pandemic but feel this case highlights a need for more effective supervision than that given to Darrell.

(3) Despite the presence of bronchopneumonia, a natural illness, it is my view that the drug combination -particularly the use of [redacted] -was the major factor in Darrell's death.

(4) I note that since Darrell's death the contract to provide drug and alcohol services in Cumbria has transferred to Humankind, and thus I am addressing the report to them as well while acknowledging that they played no part in Darrell's care.

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ACTION SHOULD BE TAKEN

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

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YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 20th January 2022. 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.

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COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to Darrell's mother.

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.

23 November 2021

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Signature

Dr Nicholas Shaw HM Assistant Coroner for