Newcastle upon Tyne Coroners
MRS KAREN L DILKS
HM SENIOR CORONER
Civic Centre , Barras Bridge , Newcastle Upon Tyne , NE1 8QH

Date: 16 September 2022
Case: 9807817

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted] Chief Executive, Tyne Housing Association, St Silas Church Building, Clifford Street, Byker, Newcastle upon Tyne, NE6 1PG

CORONER

1

I am **Karen Dilks Senior Coroner** for **Newcastle and North Tyneside**

CORONER'S LEGAL POWERS

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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

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On 8 October 2021 I commenced an investigation into the death of Colin Andrew Mark SMITH. The investigation concluded at the end of the inquest on 14.9.22 The conclusion of the inquest was

Alcohol related death.

The Cause of Death was:

1a Acute Alcohol Intoxication with Mirtazapine

1b

1c

II

CIRCUMSTANCES OF THE DEATH

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Colin A M Smith was 39yrs old with a history of Alcohol Dependence Syndrome.

He was resident at Byker Bridge House Newcastle Upon Tyne; a Hostel providing emergency accommodation for homeless persons.

In or around 6.10.21 he consumed an excessive quantity of Alcohol leading to a Blood Alcohol level of 504mg/100ml(6 1/2 times legal limit for driving). He returned to the Hostel in a Highly Intoxicated condition.

A Hostel Worker assisted him to his room and placed him on his side on the bed. Upon a welfare check by the Hostel worker approximately 2 hours later Mr Smith was unresponsive and death was later confirmed there due to the toxic effects of Alcohol.

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CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern:

Evidence was given which confirmed the absence of any training policy/programme for all hostel workers in respect of identifying the risks and signs of alcohol intoxication and circumstances indicating the need for urgent medical intervention.

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. –

(1) Lack of structured training policy/programme for ALL Hostel workers in respect of identifying risks of Alcohol intoxication and indicators/signs of those risks.

(2) Lack of training policy /programme for ALL Hostel workers re signs/indicators of need for urgent medical Intervention in Intoxication.

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ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you [redacted] 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 17th November 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 the following Interested Persons [redacted]

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.

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16 September 2022

for Newcastle upon Tyne Coroners