REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Practice Manager, The Beaufort Road Surgery**
1	**CORONER** I am Richard T Middleton, Assistant Coroner, for the Coroner Area of Dorset
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 the 23rd November 2022, an investigation was commenced into the death of Edward England Rhodes, born on the 9th July 1989. The investigation concluded at the end of the Inquest on the 27th July 2023. The Medical Cause of Death was: 1a Methadone Toxicity The conclusion of the Inquest recorded. Drug Related Death
4	**CIRCUMSTANCES OF THE DEATH** **Mr Rhodes had a long history of alcohol misuse. He had been admitted to hospital numerous times for alcohol related issues. He lived in supported housing where he was tested regularly for substance misuse. In June 2022 he chose to abstain from alcohol and sought the help and support of agencies to prevent relapse. On 14/7/22 he stated he was over 1 month sober; on 18/8/22 he was 76 days sober; on 2/9/22 he stated he was 90 days sober; and by 16/11/22 he had been abstinent for 4-5 months. At the beginning of November 2022, he relapsed. On 17/11/22 he was found on his partner's bedroom floor in an unresponsive state and was pronounced dead at the scene. Toxicology revealed the presence of methadone, which was at a level consistent with severe, possibly fatal toxicity for an individual who is naïve to or occasional user of methadone. Mr Rhodes was not on a methadone prescription at the time of his death.**

5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: 1. During the inquest evidence was heard that: i. Mr Rhodes wanted to address the underlying causes for his addiction. He wished to be referred to the Mental Health Team for an assessment. He was told by medical professionals that he needed to be 90 days sober. ii. Mr Rhodes saw his GP and it was confirmed during evidence that a referral would be made by the GP after a period of 90 days abstinence. iii. Mr Rhodes' GP explained that in order to make a referral Mr Rhodes had to make a specific appointment to discuss the Mental Health referral. The GP said that Mr Rhodes was aware of this. iv. Mr Rhodes saw his GP on 14/10/22 (at that time he had been sober in excess of 90 days) for a medical condition. On that occasion there was no discussion about the Mental Health referral. v. Mr Rhodes' family (who were close to him and had discussions with him) gave evidence to say that his understanding was that following the 90 day period of sobriety there would be an automatic referral by his GP to the Mental Health Services. vi. The report from the addiction support agency details entries whereby during discussion with his Recovery Worker Mr Rhodes provides a detailed chronology of his period of abstinence and the fact he was waiting to hear from the Mental Health Services for an assessment appointment. vii. Mr Rhodes' partner gave evidence that at the time he started to relapse he was still waiting for a date from the Mental Health Services and that he was expressing disillusionment with the Mental Health Services. 2. I have concerns with regard to the following: i. There appears to be an apparent breakdown in communication or a misunderstanding between GP and patient as to what steps needed to be taken and by whom in order for there to a Mental Health referral.

	ii. Reliance appears to have been placed on verbal discussions during consultation and in circumstances where the patent is an addict. iii. There does not appear to be a system where there would be an automatic referral by the GP to the Mental Health team after a 90 day period of sobriety unless the patient "opted out" or where following an automatic referral it is left to the Mental Health team to seek the co operation of the patient. iv. There does not appear to be a letter sent by the surgery confirming the respective responsibilities of the doctor and patient.	
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and/or your organisation 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, Tuesday 26th September 2023. 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: (1) [redacted] (2) 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	**Dated** **1/08/23**	**Signed**  **Richard T Middleton**