REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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	THIS REPORT IS BEING SENT TO: Ministry of Defence
1	CORONER
	I am Alison Mutch, Senior Coroner, for the coroner area of South Manchester
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 9 th May 2023 I commenced an investigation into the death of James Colin Day. The investigation concluded on the 26 th October 2023 and the conclusion was one of Narrative: Died from health complications arising from use of alcohol and medication to try to deal with the complications of severe post-traumatic stress disorder caused by his service in the army. The medical cause of death was 1a) Acute Left Ventricular Failure; 1b) Left ventricular hypertrophy on background of alcohol-related liver disease with superimposed combined drug toxicity; II) Post-traumatic stress disorder
4	CIRCUMSTANCES OF THE DEATH
	James Colin Day served his country. As a consequence of his deployment in Afghanistan he developed severe post-traumatic stress disorder. He was discharged from the army having received little support to help him deal with his post-traumatic stress disorder. He used alcohol to excess and prescribed medication to try and deal with his post-traumatic stress disorder. On 6 th May 2023 he collapsed on Malvern Road, Old Trafford. Attempts to resuscitate him were unsuccessful. Post-mortem examination found he had developed alcohol related liver disease which had led to left ventricular hypertrophy and an acute left ventricular failure exacerbated by combined drug toxicity.

5 | CORONER'S CONCERNS

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. -

The inquest heard evidence that James Day had served his country as a member of the armed services. He had been deployed to Afghanistan as part of his service where he had witnessed traumatic events that had led to him developing post-traumatic stress disorder. He needed support to help him deal with the trauma. However that had not been provided in such a way whilst he was serving to allow him to deal with his PTSD. He had subsequently left the army and had continued to struggle to cope with his PTSD. He used alcohol and prescribed medication to try and cope with the severe symptoms of his PTSD.

The inquest heard that support for service personnel with severe PTSD such as Mr Day whilst they were still serving and following discharge was patchy, difficult to access and did not appear to recognise how significant the impact of events they had witnessed whist serving could be on their mental health.

The inquest heard that better mental health support whilst serving and following discharge may have avoided Mr Day having to turn to self-medication to try and have respite from his PTSD symptoms.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you 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, namely by 3rd April 2024. 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 namely on behalf of the Family, who may find it useful or of interest.

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 Alison Mutch
HM Senior Coroner

07.02.2024