## Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

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| | **REGULATION 28 REPORT TO PREVENT DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br>**1 The Rt. Hon. Victoria Atkins MP, Secretary of State for Health and Social Care**<br>**2 NHS England** |
| **1** | **CORONER**<br><br>I am Alexander FRODSHAM, Assistant Coroner for the coroner area of Cheshire |
| **2** | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 14 December 2022 I commenced an investigation into the death of Oliver Walter John Stephen BARNETT, aged 17. The investigation has not yet concluded, and the inquest is part-heard. |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br><br>Oliver Barnett was aged 17 years when he died and had, since the age of 14, experimented with drugs. Oliver became dependent upon Benzodiazepines in particular, and was admitted to hospital on several occasions in 2022 following overdoses. Following hospital treatment, Oliver was discharged to substance misuse services in the community (with a prescription for [redacted] diazepam daily, a very high dose). During the inquest, evidence was given that there are no (publicly-funded) residential substance misuse treatment facilities in England for minors. On 8th December 2022, Oliver died from an overdose of illicitly obtained drugs. |
| **5** | **CORONER'S CONCERNS**<br><br>During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows:<br>(brief summary of matters of concern)<br><br>There are no residential substance misuse treatment facilities for children and young persons under the age of 18 in England. If a child is acutely unwell through substance misuse, they will be treated in hospital and then discharged home to receive treatment in the community. Parents/guardians must manage the detoxification programme, and the risk of relapse, supported by substance misuse agencies. There is a disparity between the treatment offered to adults and children, and the absence of residential substance misuse facilities places children at greater risk of relapse and death by overdose. |
| **6** | **ACTION SHOULD BE TAKEN**<br><br>In my opinion 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** |

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| | You are under a duty to respond to this report within 56 days of the date of this report, namely by July 03, 2024. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons<br><br>[redacted]<br>[redacted]<br>**Cheshire and Wirral Partnership NHS Foundation Trust**<br>**Mid-Cheshire Hospitals NHS Foundation Trust**<br>**Change Grow Live**<br>**Cheshire East Council**<br>**North Staffordshire Combined Healthcare NHS Trust**<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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.<br><br>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: 08/05/2024**<br><br>  <br>**Alexander FRODSHAM**<br>**Assistant Coroner for**<br>**Cheshire** |