REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chief Executive of County Durham and Darlington NHS Foundation Trust.** **2. [redacted], Chief Executive of Tees, Esk and Wear Valleys NHS Foundation Trust**
1	**CORONER** I am Janine Richards, assistant coroner, for the coroner area of Durham and Darlington
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 17th of October 2022 an investigation was commenced into the death of Andrew James Naylor, aged 37 years. The investigation concluded at the end of the inquest on the 3rd of June 2024. I gave a narrative conclusion as follows :- Andrew James Naylor was found deceased on the 11th of October 2022 at Drury Lane, Durham City. He died as a result of the combined central nervous system depressant actions of alcohol, [redacted] and [redacted]. The [redacted] had been administered to the deceased during his hospitalisation subsequent to an overdose, and to manage the symptoms and effects of alcohol withdrawal. He was not advised of the specific and potentially fatal risk of respiratory depression should he drink or misuse drugs in combination with the [redacted] or the [redacted] he had ingested, and no full consideration was given to the safety of the discharge, given the deceased was a chronic alcoholic likely to drink alcohol and or take drugs upon discharge, and was homeless having been evicted from his supported accommodation. In particular, the mental health team in the hospital did not inform the medical clinicians that the deceased was homeless, which would have delayed his discharge until a place of safety was identified. There was no consideration of contacting the deceased's family or friends who may have provided an essential safety net in the absence of professional support, nor as to how he was to contact or be contacted by community support services such as community mental health or drug and alcohol services in the absence of a postal address or mobile phone. Poor communication between the various agencies involved led to a failure to ensure a robust safety plan was in place. These cumulative failures contributed more than minimally to the death.

	The medical cause of death was :- 1a) Acute Cardiorespiratory failure 1b) Central Nervous System Depressant Actions of Alcohol, [redacted], and [redacted]
4	**CIRCUMSTANCES OF THE DEATH** Andrew James Naylor was found deceased on the ground in Drury Lane, Durham City on the morning of the 11th of October 2002 . He had been discharged from the University Hospital of North Durham the day before, subsequent to treatment for a drug overdose, which included the administration of drug [redacted] to treat his alcohol withdrawal. He was known to have mental health, drug and alcohol issues. It was known, or ought to have been known that he was homeless having been evicted from his supported accommodation.
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 could 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) There is no specific protocol or policy in place to ensure that patients are warned of the acute risk of respiratory depression and death following administration of the drug [redacted], should they drink alcohol or misuse drugs. (2) There appears to be a lack of a joined up process between acute clinicians, alcohol and drug treatment teams, and mental health teams, to consider the safety of a discharge, and to ensure that crucial information relevant to risk is shared appropriately (which may also be, to an extent, hampered by a continuing inability to see each other's records), and whether discharge should be delayed or care stepped down, until a place of safety is identified, and to ensure that a robust safety plan is in place upon discharge. (3) There was no consideration given by either the acute or mental health teams to contacting the deceased's family or friends, which may have provided an essential safety net in the absence of accessible professional support. The TEWV Trust are candid that work in relation to this issue is a work in progress and remains incomplete. (4) Although both Trusts indicated that they are in the process of addressing the concerns raised in this Inquest, I consider that at the time of the conclusion of this Inquest that there remains a risk that future deaths could arise.
6	**ACTION SHOULD BE TAKEN** 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** You are under a duty to respond to this report within 56 days of the date of this report, namely by 31.07.24 . 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; the family of the deceased. I have also sent it to the Care Quality Commission 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	**04.06.24**