REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Greater Manchester Integrated Care Board
1	CORONER I am Alison Mutch , senior coroner, for the coroner area of Manchester South
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 29th October 2024 I commenced an investigation into the death of Robert Leighton SMITH. The investigation concluded at the end of the inquest on 10th March 2025. The conclusion of the inquest was Accidental death. The medical cause of death was **1a) Concomitant Dihydrocodeine and Pregabalin Toxicity.**
4	CIRCUMSTANCES OF THE DEATH On 25th October 2024, Robert Leighton Smith was found unresponsive at his home address, [redacted]. He was on high levels of prescribed painkillers for pain. He had a history of mental health difficulties and was on the waiting list for Interpersonal Psychotherapy (IPT). Police found no suspicious circumstances and no evidence of third party involvement in his death. A post mortem included toxicology. He was found to have above therapeutic levels of his prescribed medication in his system
5	<u>CORONER'S CONCERNS</u> 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. –

	The inquest was told that Mr Leighton –Smith had been assessed as someone who would gain a real benefit from IPT. However he had not started it at the time of his death due to a significant waiting list. This was caused by the demand for the service being far higher than the capacity. The evidence was that at the time of the inquest the waiting time for IPT was on average 12 months. This was due to the ongoing demand against commissioned capacity. The inquest was also told that IPT was not an outlier in relation to its waiting time and that the backlog for all other therapy type services were at a similar level. The consequence of such prolonged waits was that people were having to wait a long time for mental health therapy support that they had been identified as requiring. The Trust GMMH indicated they provided the services they were commissioned to provide but unless the additional services were commissioned they could not increase their provision and waiting lists would remain high.
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 **5th June 2025**. 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 the following Interested Persons : Mr Smith's daughters on behalf of the family, GP and Pennine Care Foundation Trust 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. They may send a copy of this report to any person who they believe 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**  **10th April 2025**