

**ANDREW COUSINS  
HM ASSISTANT CORONER**

**County of Cumbria**



**Allerdale House  
New Bridge Road  
Workington, CA14 3YJ**



	<p style="text-align: center;"><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p style="text-align: center;"><b>DARREN ROBERT DICKSON</b></p> <p>THIS REPORT IS BEING SENT TO:</p> <p><b>Recovery Steps of 6 Finkle Street, Workington, CA14 2AY</b></p>
1	<p><b>CORONER</b></p> <p><b>I am Mr Andrew Cousins HM Assistant Coroner for the County of Cumbria</b></p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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:</p> <p><a href="https://www.legislation.gov.uk/ukpga/2009/25/contents">https://www.legislation.gov.uk/ukpga/2009/25/contents</a></p> <p><a href="http://www.legislation.gov.uk/uksi/2013/1629/contents">http://www.legislation.gov.uk/uksi/2013/1629/contents</a></p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 10 and 11 March 2026, I heard the inquest into the death of Mr Darren Robert Dickson, aged 35 years, at the time of his death on 6 February 2025. The investigation concluded at the end of the inquest, where I returned a narrative conclusion, and found the cause of death to be 1(a) Toxic effects of alcohol and benzodiazepine II Ischaemic heart disease and possible hypertrophic cardiomyopathy.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>I found that Darren Robert Dixon resided at 35 Gote Road, Cockermouth, Cumbria. Darren was employed as a mental health adviser at Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust.</p> <p>Mr Dickson had been experiencing a period of mental ill health following witnessing an extremely traumatic incident at his place of work. Mr Dickson had sought medical</p>

treatment for this mental health condition. Independent to this, Mr Dickson had started to take benzodiazepine to assist his condition. Mr Dickson had sought assistance from his employer, his GP and Recovery Steps in relation to his mental health condition and use of benzodiazepine.

It is not possible on the balance of probabilities to determine the exact extent of the advice provided to Mr Dickson in relation to the ongoing use of benzodiazepine after 24 January 2025.

Having last been seen at approximately 9pm on 5 February 2025, Mr Dickson was found unresponsive at 35 Gote Road. Mr Dickson was taken to West Cumberland Hospital where, despite treatment, he died on 6 February 2025. Toxicology analysis showed the presence of benzodiazepine and alcohol in Mr Dickson's body, at levels that, on the balance of probabilities, led to his death.

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**CORONER'S CONCERNS**

During the course of the inquest the evidence revealed two 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:

- (1) At the appointment on 27 January 2025, Mr Dickson was seen by a Recovery Co-Ordinator in relation to his use of benzodiazepine. It could not be ascertained from the records what information regarding signposting to other services that could have assisted Mr Dickson with treatment, was provided to him. I was concerned that the records did not allow a full and verifiable understanding of the information and assistance provided to Mr Dickson at this appointment.
- (2) At the appointment on 27 January 2025, Mr Dickson was given advice to prepare a 'drugs diary'. This was required so that, at his follow up appointment, it could be ascertained what his usage of benzodiazepine he was, so that a better-informed treatment plan could be prepared. I was conscious of the need your staff have for accurate information as to the extent of the drug use so that a well informed and coherent plan could be put in place. The concern I had was that Mr Dickson had seen his GP prior to the appointment on 27 January 2025 and had been told that if he was to take any benzodiazepine, it should be less than what he had previously taken. I was concerned that there was scope for confusion as to the information being

	<p>given to Mr Dickson, and the level of communication that Recovery Steps has with the GP services in relation to the issue of ongoing use and doses of drugs.</p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe that</p> <p><b>Recovery Steps</b></p> <p>has the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by <b>11 May 2026</b>.</p> <p>I, the Coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:</p> <p>██████████ ██████████</p> <p>Castlegate &amp; Derwent Surgery Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust.</p> <p>I have also sent a copy to:</p> <p>DAC Beachcroft – legal representative for CNTW</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>The Chief Coroner may publish either or both in a complete or redacted or summary form. She 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</p>

	of your response, about the release or the publication of your response by the Chief Coroner.
9	Dated this 16 day of March 2026  <b>Mr Andrew Cousins LL.M MRes</b> <b>HM Assistant Coroner</b> <b>County of Cumbria</b>