REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Chief Executive South West London and St George's Mental Health Trust, Springfield Hospital, 61 Glenburnie Road, London. SW17 7DJ [redacted] Chair, NHS Care Commissioning Group 73 Upper Richmond Road London SW15 2SR
1	**CORONER** I am Dr Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West London
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 8th November 2016, and 25th November 2016, I heard the inquest touching the death of Jaroslaw Rogala (otherwise known as Jarek). **Medical Cause of Death** 1 (a) Hanging **How, when and where and in what circumstances the deceased came by her death:** Jarek was dependent on alcohol. When intoxicated he suffered with suicidal ideation. On 3/9/2016 he was found hanging in his bedroom deceased. There were no suspicious circumstances. He was heavily intoxicated at the time of his death. **Conclusion as to the death**

	He took his own life whilst intoxicated with alcohol
4	**CIRCUMSTANCES OF THE DEATH** In the days leading up to his death he had attended St George's Hospital on the 30th and 31st August consecutively with suicidal ideation in association with social stress and alcohol misuse. On each occasion he was seen by Liaison Psychiatry and discharged to GP follow up. Admission had been requested but he was told that there was nowhere that he could be admitted to. He was not sectionable under the Mental Health Act. In evidence the court heard that there is no facility to admit patients in whom the primary diagnosis is dependence on drugs or alcohol under the psychiatric services in such circumstances. Further admission under the medical teams for detoxification requires a medical indication. As such there is no ability to admit such a patient into a "safe" space when in crisis for care and supervision. Essentially patients with dependence are thus discriminated against by psychiatric services, with addiction being regarded as a personal choice on the part of the patient rather than being treated as an illness.
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. – That those patients with addiction are risk of suicide as there are no in-patient facilities to admit them for care and supervision when in crisis in circumstances as described in this case.
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. 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 : [redacted]

	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	**14th December 2016**  **Dr Fiona J Wilcox** **HM Senior Coroner** **Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED**