ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. South London and Maudsley NHS Trust** **2. Kings College Hospital** **3. Secretary of State for Health**
1	**CORONER** I am Dr Julian Morris, assistant coroner, for the coroner area of Inner London 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** I commenced an investigation into the death of Jamie Pashley, aged 32. The investigation concluded at the end of the inquest on 7 November 2016. The conclusion of the inquest was accidental death caused by alcohol intoxication. The medical cause of death was 1a Alcohol intoxication, II Alcoholic liver disease. Jamie died on 26 August 2015.
4	**CIRCUMSTANCES OF THE DEATH** Jamie presented to the medical services and was acknowledged as suffering from an alcohol problem requiring detoxification in January 2015. He had had a 2 year escalation of intake. He was abstinent for 21/2 months before starting, under control, again. On 4 August 2015 he was admitted to KCH following an alcohol withdrawal seizure. He completed his detoxification and was discharged on 7 August 2015. He was asked to proactively engage with Lorraine Hewitt House alcohol team and/ or Lambeth IAPT (improving access to psychological services). He saw his GP on 14 August 2015 when he was started on anti-depressants. He had a telephone contact with Lambeth Talking Therapies on 20 August and was advised, due to his alcohol, to engage with the alcohol service first. He was found in his flat on 26 August 2015. Subsequently, he was found to have high levels of alcohol in his body.
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. – Whilst understanding and appreciating that dealing with anxiety and alcohol dependence can be difficult, and taking into account the issue of resources, I would ask that the reliance upon an individual to proactively manage their rehabilitation be reviewed and

	re-assessed. Issues concerning the younger generation and alcohol are increasing and with the risk of relapse being potentially higher in the time soon after discharge I would ask that the following be reviewed: (1) whether, upon discharge after detoxification, individuals ought, in addition to receiving information regarding access to Lorraine Hewitt House Aftercare Programme and signposting them to a drop in clinic, to be provided with a fixed appointment; (2) whether telephone contact should also be made with an individual between discharge and first appointment review; (3) whether there is a need to increase the availability of an alcohol liaison nurse currently provided between the hours of 0900-1700,Monday to Friday, at the hospital for the individual to access, given they have met that person whilst an in-patient.
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 25 August 2017. 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] 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	**28 May 2017** **Dr Julian Morris**