VERONICA HAMILTON-DEELEY DL, LL.B. Her Majesty's Senior Coroner for the City of Brighton & Hove

Assistant Coroners CATHARINE PALMER LL.B (HONS) KAREN HENDERSON, BSC,BM,MRCPI,FRC GILVA D.J.TISSHAW, BA(LAW)HONS

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CORONERS SOCIETY OF ENGLAND AND WALES

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	THIS REPORT IS BEING SENT TO:
	 Clinical Commissioning Group Sussex Partnership NHS Foundation Trust Pavilions (Surrey Borders Trust) and
1	CORONER
	I am Veronica HAMILTON-DEELEY, Senior Coroner, for the City of Brighton and Hove
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 Nineteenth April 2017 I commenced an investigation into the death of Thomas Christopher WALL . The investigation concluded at the end of the inquest on First August, 2017. The conclusion of the inquest was HE TOOK HIS OWN LIFE.
4	CIRCUMSTANCES OF THE DEATH
	See Record of Inquest
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.

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	The MATTERS OF CONCERN are as follows. –
	THE WATTERS OF CONCERN are as follows. —
	(1) That there is no local in-patient detox facility such as used to exist at Millview Hospital. It is not acceptable that local people needing in-patient detox have to travel to Islington away from family and friends. It is also unacceptable that the waiting list is so long especially when often Mental Health will not be fully addressed until detox has taken place. How many dual diagnosis patients are there in the UK?
	(2) A much more collaborative approach to dual diagnosis patient's treatment is needed. The dual diagnosis is at the heart of this problem. It is not appropriate to try to separate each component and only agree to treat/assess one component when the other is dealt with. The dual diagnosis is the person. When in crisis they are doubly at risk. That period of risk should be reduced as quickly as possible. The delays and refusals serve to exacerbate the patient's distress and increase their despair.
	As Thomas Wall said in a text message to his supportive ex-wife. 'I want to get better but I can't do that on my own whereas I can take my life on my own'
6	ACTION SHOULD BE TAKEN
	In my opinion action should be taken to prevent future deaths and I believe you AND 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 23 rd October 2017. I, the coroner may extend the period.
٠.	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
·	Secretary of State for Health, Department of Health Simon Stevens – Chief Executive NHS England

3. National Patient Safety Agency

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	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	Date: 2 nd August 2017 SIGNED BY: Senior Coroner Brighton and Hove