REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Rt Hon Matt Hancock MP** **Secretary of State** **Department of Health and Social Care** **39 Victoria Street** **London** **SW1H 0EU**
1	**CORONER** I am Nigel Parsley, Senior Coroner, for the coroner area of Suffolk.
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 24th March 2020 I commenced an investigation into the death of **Piotr Marek KIERZKOWSKI** The investigation concluded at the end of the inquest on 23rd September 2020. The conclusion of the inquest was that the death was the result of:- **Suicide, whilst suffering from a psychotic episode.** The medical cause of death was confirmed as: **1a Incised wound to the neck**
4	Piotr Kierzkowski was found deceased on the 17th December 2019 at his home address of [redacted], Bury St Edmunds in Suffolk. When found, Piotr had barricaded himself into his bedroom which was subsequently forced open by police officers. Officers had been called, as Piotr's landlady had looked through the window of his ground floor bedroom and seen blood on the bedding and walls. When officers entered, they found Piotr was slumped on the floor with his back against the wall, a large pool of blood surrounded him and a knife was found close to his body. The day before his death (16th December 2019) Piotr, who had a history of mental illness, had suffered a mental health crisis and had been taken to his GP by a concerned friend. His GP immediately referred Piotr for a review by mental health professionals and his friend then took him to the Accident and Emergency department of the West Suffolk Hospital, Bury St Edmunds for this to be undertaken.

	Once there, Piotr was seen and assessed by mental health practitioners, who wanted to immediately admit Piotr as an informal patient onto the hospital's Psychiatric Unit. It was also Piotr's wish that he was admitted as an informal patient. However, the unit was at capacity and no other beds were available within Suffolk itself, or elsewhere in the country at that time. As a result, late in the evening of the 16th December Piotr was sent home with a friend and told to return at 10:00 the next morning when a bed would be available. Piotr was last seen alive outside his bedroom at his home address at approximately 07:00 on the 17th December, before he returned into that room. Piotr took his own life shortly before he was due to be returned to the hospital by his friends.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters given 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** as follows. – In evidence it was heard that Piotr had not received his 'depot' medication for some time and was clearly suffering from a psychotic episode at the time of his assessment at the Accident and Emergency department of the West Suffolk Hospital on the 16th December 2019 Piotr told staff he was not actively suicidal at that point in time, and although the staff were concerned about his presentation, under mental health law least restrictive principles, they did not believe the powers of detention under the Mental Health Act were applicable. That said, it was also clear from the evidence that the mental health personnel who saw Piotr wanted to immediately admit him as an informal patient. It was also clear that when Piotr attended hospital on the 16th December 2019, he too wanted to be immediately admitted as an informal patient. As a result, staff tried to locate a bed for Piotr so he could be admitted as all involved wished. However, it was identified that there were no beds available in Suffolk, or anywhere else in the country at the time. Different options of keeping Piotr in the hospital were explored but none were viable. As such, Piotr was prescribed medication to reduce his immediate anxiety and sent home with a friend, with instructions to return if his symptoms deteriorated. Piotr took his own life the next morning before he could be returned to hospital. Had a bed been available and Piotr had been admitted as he and medical staff had wished on the evening of the 16th December 2019, his death would not have occurred.

	I am therefore concerned in relation to the overall bed capacity for those patients like Piotr seeking informal admission. In addition, I am concerned about the provisions to temporarily house a patient wishing informal admission in the circumstances that a bed is not immediately available.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken in order to prevent future deaths, and I believe you or your organisation have the power to take any such action you identify.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 8th December 2020 I, the Senior Coroner, may extend the period if I consider it reasonable to do so. 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;- 1. Piotr's next of kin. 2. Chief Executive of the Norfolk and Suffolk NHS Foundation Trust I am 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**12th October 2020** **Nigel Parsley**