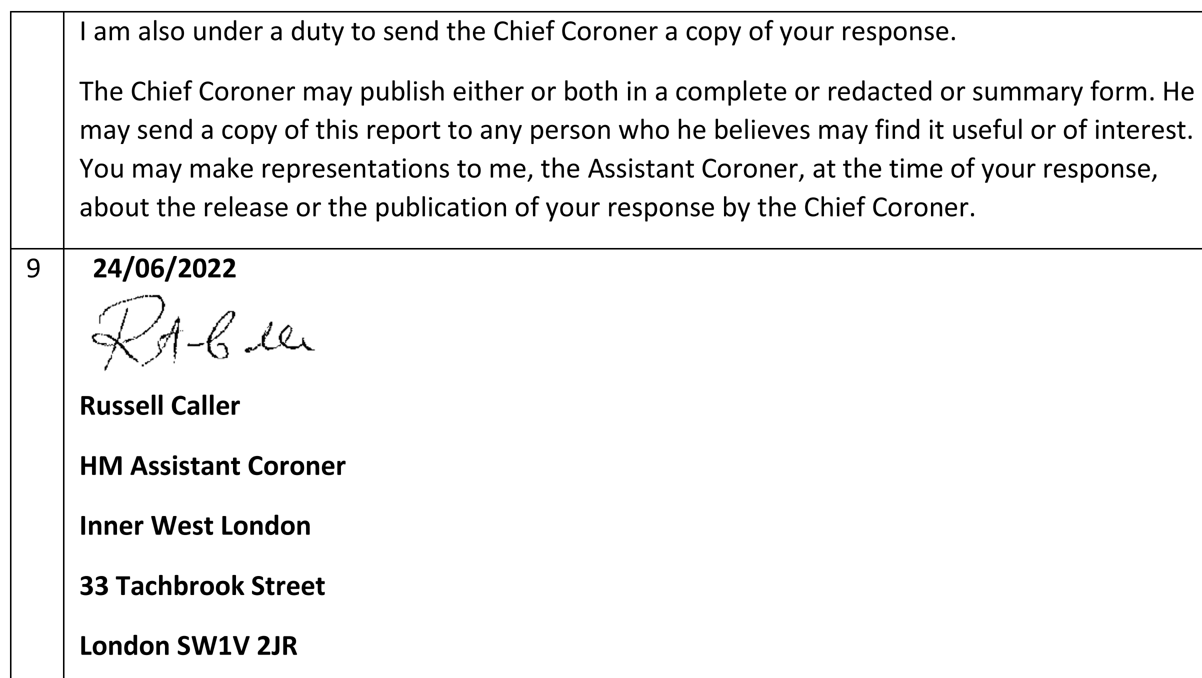
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] The Portland Practice, 16 Portland Road, London W11 4LA ("The GP") 2. Central and North West London NHS Foundation Trust 350 Euston Rd, London NW1 3AX ("CNWL Trust") 3. Imperial College Health Care NHS Trust The Bays South Wharf Road St Mary's Hospital London W2 1NY ("IHC Trust") 4. West London NHS Trust 1 Armstrong Way, Southall UB2 4SD ("WL Trust")
1	**CORONER** I am Russell A Caller, HM Assistant Coroner, for the Coroner Area of Inner London West
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 14th March 2021 I commenced an investigation into the death of ZSOLT KIRJAK then aged 45. The investigation concluded at the end of the inquest on 17th June 2022. The Conclusion of the Inquest was Suicide. **Medical Cause of Death** 1 (a) Left Pneumothorax and Hemopericardium 1 (b) Stab wounds to the Chest.
4	**CIRCUMSTANCES OF THE DEATH:** ZSOLT KIRJAK had been suffering with Tinnitus and lack of sleep for some considerable time He tried to obtain health assistance from a number of Health Care Agencies including The GP, CNWL Trust, IHC Trust and WL Trust. However, ZSOLT KIRJAK could not obtain the health care he required. Moreover, ZSOLT KIRJAK became nervous and very anxious and to each of the health agencies he visited he said that he had attempted suicide previously and he still had suicide ideation. As a result on his not being able to resolve his medical and psychiatric issues on 14th March 2021 14 ZSOLT KIRJAK drove his car to [redacted] leading to his death.

5.	**CORONER'S CONCERN** 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: 1. ZSOLT KIRJAK was found to have ended his life following a succession of emergency presentations for persistent ENT symptoms and associated psychological distress including acute suicidal thoughts. 2. The Psychiatric assessment 4 (four) days prior to the Patient's death was incomplete, particularly with regards to his psychiatric history (including previous attempts at self harm and the documented recent attempt by the patient to give himself a stroke), substance use and medical history. Correspondingly, there was an insufficient risk assessment that did not include or appraise the Patient's risk factors for suicide. The treatment plan prescribed did not manage the Patient's risks. 3. There was a lack of enquiry by any of the clinicians who had seen the patient into the Patient's previous attempt to give himself a stroke and a subsequently acquired eye injury. It is very unusual for a patient to attempt to give oneself a stroke and would reasonably be expected to warrant a detailed assessment because it implies a high degree of harm and lethality. 4. Though there was contact between the LPS clinician and the Patient's wife, there is no evidence as to whether the Patient's wife was given the opportunity to contribute to his clinical and risk assessments and corresponding management plan.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 Assistant 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 namely [redacted] of Littlemead, Lyndhurst Road, Mossley Hill, Liverpool, L18 8AU

	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 Assistant Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**24/06/2022**  **Russell Caller** **HM Assistant Coroner** **Inner West London** **33 Tachbrook Street** **London SW1V 2JR**