West London Coroner Service
25 Bagleys Lane, Fulham, London, SW6 2QA
[redacted]

Date: 21 August 2023
[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: HILLINGDON COUNCIL

Family, Forward Trust, Central and North West London Mental Health Trust, CHIEF CORONER

I am **Mrs. Lydia Brown** the Acting Senior Coroner for **West London**
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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
INVESTIGATION and INQUEST

On 16 August 2022 I commenced an investigation into the death of Jacqueline Elizabeth SMITH. The investigation concluded at the end of the inquest . The conclusion of the inquest was

suicide

Cause of death -

1a Respiratory depression

1b [redacted] overdose, [redacted]

1c

II
CIRCUMSTANCES OF THE DEATH

Took her own life by an overdose of prescribed medication at home and died in Hillingdon Hospital on 12 August 2022.
At the time she was in poor physical health and experiencing considerable anxiety as she was trying, with assistance from the Council, to clear her home of numerous hoarded possessions. She spoke with the single point of access (SPA)

crisis telephone service during the evening of 10th August to ask for help, but no mental health assessment was performed and she was not called back by the team as promised. Her neighbour requested a welfare check be performed the next day when she was found collapsed and taken to hospital.

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. -

Mrs Smith was recognised to be a hoarder and her council property was dangerously full of items blocking all access, impeding stair access and impacting on her ability to access the kitchen or bathroom. The gas supply had been cut off as she did not allow access for the annual inspection.

Mrs Smith recognised she had a problem and asked the council for assistance. The offered solution only moved some of her belongings into a local "void" property that she did not have access to with no plan for how to resolve this temporary situation, creating considerable anxiety and stress for Mrs Smith who then took her own life by overdosing with her prescribed medication

(1) The inquest identified that there was insufficient staff training to deal with complex hoarder cases.

(2) Other safety assessments such as a fire assessment and/or environmental health assessment were not requested despite their being a clear need.

(3) The council "flow chart" was clearly not fit for purpose to assist staff in progressing hoarder support and assistance and was focussed on enforcement procedures rather than tenant support. The inquest was advised that the council's approach was not enforcement, but their documentation did not support this.

(4) It was entirely unclear what options were available (if any) when the first plan of assistance completely failed, leaving the vulnerable tenant excluded from her property with no forward plan.

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you Hillingdon Council have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report,
7 namely by 16th October 2023. 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.

COPIES and PUBLICATION

8 I have sent a copy of my report to the Chief Coroner and to the following Interested Persons, Family, Forward Trust, Central and North West London Mental Health Trust

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.

21 August 2023

Signature 

9 Acting Senior Coroner