Regulation 28: Prevention of Future Deaths report

Igor Kacper SZALAPSKI (died 30.04.23)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Chief Executive** **Depaul UK** **Sherborne House** **4 Decima Street** **London SE1 4QQ**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 15 May 2023, one of my assistant coroners, Jonathan Stevens, commenced an investigation into the death of Igor Szalapski, aged 18 years. The investigation concluded at the end of the inquest on 1 November 2023. I apologise for the delay in the provision of this report. At inquest, I made a determination of death by suicide.
4	**CIRCUMSTANCES OF THE DEATH** Igor hanged himself in his room at the Depaul London Youth Hub (a hostel for homeless young people) on Sunday, 30 April 2023.
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.

On 28 March 2023, Igor refused to get out of the shower [redacted]. Hostel staff took various actions, including calling the crisis team. The crisis team decided that Igor did not need daily visits, but told staff to call back if there was any change or further concern.

1. On 14 April 2023, staff found Igor outside, drowsy and incoherent, cold and wet, but did not re-contact the crisis team.

2. Igor was a vulnerable young man, recently homeless, but the last time that any member of staff had a meaningful conversation with him was on 20 April 2023, ten days before he died.

3. The Depaul executive director of services recognised at inquest that there should have been more staff conversation with Igor throughout his time at the London Youth Hub.

4. She also acknowledged that greater attempts should have been made by staff to engage with partner agencies regarding Igor's care and welfare.

5. Igor was only 18 years old and his father did visit him, but the hostel did not have any contact details for his family.

I heard evidence at inquest that Depaul conducted an internal investigation into Igor's death. The fact of the report was not disclosed to my office in advance of the inquest as it should have been, and I did not see it until it was mentioned in evidence at the inquest.

However, I have read the report since. It went into some detail and identified that, when Igor was found at 6.25pm, no staff member had undertaken a welfare check of him since half past midnight, whereas there should have been at least one per shift. I was told at inquest that staff were disciplined about this after Igor's death.

At the time of Igor's death, there was no national policy on when to increase welfare checks. I was told that there is now national guidance.

The Depaul investigation also identified that staff at the London Youth Hub had not attended self harm and suicide awareness training. I heard that training has now increased and is mandatory.

The report described the culture at the London Youth Hub as chaotic.

6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 8 January 2024. 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 following. • [redacted], parents of Igor Szalapski • Care Quality Commission for England • HHJ Thomas Teague QC, the Chief Coroner of England & Wales I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**DATE** **SIGNED BY SENIOR CORONER** 13.11.23 *ME Hassell*