ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NHS England** **2. Minister for Public Health, Department of Health & Social Care** **3. Parliamentary Under Secretary for local government funding, Department of Levelling Up, Housing and Communities** **4. SE London Integrated Care Board**
1	**CORONER** I am Andrew Harris, assistant coroner for the coroner area of Outer South London
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 21 September 2023 an investigation was commenced into the death of Emily Rose Collishaw, aged 35. The investigation concluded at the end of the inquest on 18 June 2024. The medical cause of death was recorded at inquest as Sudden Unexplained Death in Alcohol Misuse. The narrative conclusion read: **Alcohol Related Death: Neither intoxication nor ketoacidosis were the direct cause of death. she was recovering from a recent high alcohol intake and probably died from an associated arrhythmia.**
4	**CIRCUMSTANCES OF THE DEATH** As recorded on the Record of Inquest: **Emily was found dead with rigor mortis in her flat on Wednesday 6th September 2023 in non suspicious circumstances. She was suffering from alcohol dependency, drinking several bottles of wine daily. She had begun treatment for substance misuse with Pier Road Project in December 2022, having regular contact with a key worker. In June 2023 Bexley Home Treatment Team managed her mental health care, following admission to hospital with injuries from a fall, whilst intoxicated. Her family felt that she was not competent to self discharge, a view not supported by a psychiatrist. Clinical staff visited and she was often intoxicated until discharge from their care on 4th July to Pier Road Project. She was referred for in patient rehabilitation suitability assessment, but a placement was not available until November 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 could 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. Emily's mother reported that it took some time for the organizations working with her daughter to agree their roles and that the degree of support was insufficient to maintain her physical health or promote abstinence over such a long period of six months before she died. The family felt that the referral for residential care should have been made earlier, especially as her housing situation was a risk to her health. It was accepted that Emily did not engage consistently but did reduce intake on a number of occasions, only to relapse. 2. The inquest heard from professionals that the period of waiting for a residential rehabilitation placement was about three months, but could be as long as seven months. Evidence was heard from the manager of the Pier Project that the delay in accessing residential care had been progressively getting longer over the last 10 years, which posed risks such as sudden death to patients.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations have the power to take such action. The increasing delays in accessing residential alcohol rehabilitation services is brought to the attention of organizations that commission and fund services.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 28 December 2022. 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 Chief Coroner and to the following Interested Persons: • [redacted] (mother) and [redacted] (brother) • South London & Maudsley NHS Trust (Pier Project) • Oxleas NHS Trust (Bexley Home Treatment Team) • Royal College of Psychiatrists 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	**27 June 2024** **Assistant Coroner Professor Andrew Harris**