REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • [redacted] - Parliamentary Under-Secretary of State for Public Health and Prevention via [redacted] • [redacted] - Parliamentary Under-Secretary of State (Minister for Homelessness and Democracy) via Ministry of Housing, Communities and Local Government. 2 Marsham Street. London. SW1P 4DF.
1	**CORONER** I am R Brittain, Assistant Coroner for Inner London North.
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	**INVESTIGATIONS and INQUESTS** Mr Alexi Susiluoto died on 22/5/24. An investigation into his death was opened on 5/6/24. The inquest was part-head on 27/9/24 and concluded on 31/1/25. I reached the conclusion that Mr Susiluoto died from an alcohol-related death.
4	**CIRCUMSTANCES OF THE DEATH** Mr Susiluoto was born in Finland on 16/9/92. He had lived in the UK for several years and had a significant medical history of mental health disorders, substance misuse and epilepsy (following a head injury). At the time of his death, Mr Susiluoto was homeless but being housed by Camden Council in various hotels across London, depending on availability. He continued to suffer from alcohol misuse and had periods of binge drinking. He was under the care of Turning Point for this issue and had previously been reviewed by multiple mental health trusts, depending on his location at the particular time of referral/review. Mr Susiluoto was found deceased in a hotel room on 22/5/24. The cause of his death was alcohol misuse disorder resulting in acute ethanol toxicity. Contributing factors were epilepsy and Olanzepine and Levetiracetam use (prescribed medication).
5	**CORONER'S CONCERNS** During the course of this 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** following the inquest into Mr Susiluoto's death were as follows:

	1. I heard evidence that the Office for Health Improvement and Disparities is currently undertaking a review of how patients with dual diagnoses (substance misuse and mental health disorders) are treated. I was concerned by two related issues: a. That substance misuse and mental health treatment is routinely provided by different organisations, despite close interplay between these conditions and that this can result in significant complexities for agencies caring for the same patient. I understand that this aspect is part of the current review; b. However, I also heard that the review is not taking into consideration the additional issues that arise when a patient with dual diagnoses is also homeless. Evidence presented at the inquest set out that this already complex situation is often compounded by homelessness, since individuals are often moved between temporary accommodation and therefore between different mental health trust and substance misuse providers. In Mr Susiluoto's case, this resulted in significant confusion as to who was providing his care and which local authority would fund potential substance misuse treatment.
6	**ACTION COULD BE TAKEN** In my opinion action could be taken to prevent future deaths and I believe that the addressees 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 30 May 2025. 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, Mr Susiluoto's family, East London NHS Foundation Trust, Turning Point and Central and North West London NHS Foundation 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. She may send a copy of this report to any person who she 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.
9	4 April 2025  **Assistant Coroner R Brittain**