REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • [redacted], Consultant in Anaesthesia and Pain Medicine, Complex Spine Clinic, Princess Grace Hospital, London
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 Patrick Viles died on 15/7/24 at the age of 28 years. An investigation into his death was opened on 23/7/24. The inquest was concluded on 9/5/25. I reached the conclusion that Mr Viles died from suicide.
4	**CIRCUMSTANCES OF THE DEATH** Mr Viles suffered from back pain, depression and insomnia. He was under the care of several doctors, including both NHS and private providers for these conditions. He had suicidal ideation on several occasions and had previously overdosed on medication. He took a further intentional overdose of medication, including [redacted], [redacted] and [redacted], at his home residence and died as a consequence of this act. I determined that he intended to end his life.
5	**<u>CORONER'S CONCERNS</u>** 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 Viles' death were as follows: 1. I heard evidence from several medical professionals regarding the risks that Mr Viles posed to himself and that this risk was recognised prior to his death. You provided a statement, dated 5/1/25, for the inquest which set out the interventions that you and your colleagues had undertaken to treat Mr Viles' back pain in 2023 and 2024. No reference was made to any prescriptions that you issued and therefore, given the medical cause of death that had been proposed, I did not summons you to attend the inquest.

	You did note that you had referred Mr Viles to a psychologist, who consulted with him on 19/6/24 and raised concerns regarding the need for urgent psychiatric input, given his suicidal ideation. You also noted that you reviewed him after the psychologist's input and concluded that he was not suitable for spinal cord stimulation. At the inquest it could not be determined from where Mr Viles had obtained the medication on which he overdosed. I therefore wrote a letter of concern to you, asking if you had prescribed medication (as had been suggested by the mental health trust's evidence). You replied on 13/6/25, setting out that you had prescribed four weeks' worth of [redacted] on 28/6/24 (nine days after the psychologist's consultation). I am concerned that you prescribed this medication after the psychologist you had referred Mr Viles to had raised significant concerns regarding his mental health.
6	**ACTION COULD BE TAKEN** In my opinion action could be taken to prevent future deaths and I believe that the addressee has 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 15 August 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, CQC, Mr Viles' family, North London NHS Foundation Trust, [redacted], James' Place, One Bright, [redacted], [redacted]. 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	20 June 2025  **Assistant Coroner R Brittain**