MR G IRVINE
SENIOR CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], The Commissioner of Police of the Metropolis** [redacted]
1	**CORONER** I am Graeme Irvine, senior coroner, for the coroner area of East 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 26th January 2024, this court commenced an investigation into the death of Jake Hickey Girton aged 41 years. The investigation concluded at the end of the inquest on 25th September 2025. The court returned a narrative conclusion. *"Jake Hickey Girton was found deceased at home on 26th January 2024, his death was caused by alcohol and dihydrocodeine toxicity on a background of cardiorespiratory illness. It has not been possible to credibly explore Jake's intent at the time of his death, he was intoxicated by alcohol."* Mr Hickey Girton's medical cause of death was determined as; 1a Acute Respiratory Failure 1b Combined Drug And Alcohol Use

	II Ischaemic Heart Disease, Fatty Liver Disease, Chronic Obstructive Pulmonary Disease
4	**CIRCUMSTANCES OF THE DEATH** On 8 December 2023 the deceased was admitted to psychiatric hospital, under section 2 of the Mental Health Act 1983 due to suicidal ideation on a background of serious and sustained alcohol misuse. Mr Girton was on court bail issued 27 December 2023, with conditions including issuing of a GPS tag and to attend hospital appointments. By the 5/1/24 he remained in hospital, his section discharged, he was treated voluntarily and was deemed suitable for discharge. Discharge was delayed as Jake was homeless, pending acquisition of an address. On 17th January 2024 the deceased became frustrated and aggressive on the ward, a violent incident occurred, police were called and Mr Girton was arrested on suspicion of GBH and criminal damage. Mr Girton was formally discharged from the ward. Mr Girton was taken into police custody, after a short period of detention, a decision was made to bail Mr Girton pending further inquiries. He was released from custody at 21:30 on the same day. Despite being the complainant in the criminal complaint, the psychiatric Trust were not informed of Mr Girton's release. On 26th January 2024 at 15:53 police attended Mr Girton's home address, following a call from his mother who was concerned for his welfare. By the time of their arrival Jake's mother forced entry to the locked property and found him deceased in a bedroom.
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. Evidence heard from a Metropolitan Police Inspector at inquest indicated that the police officer who was investigating the offence for which Jake was arrested was under an obligation to inform that complainant (the hospital) of Jake's release from custody. There is no evidence to suggest this was done. Evidence from the Psychiatric trust at inquest indicates that on the 17th January 2024, there were under the impression that Jake would remain in police custody, and had they known he was released, greater efforts may have occurred to support Jake in the community. 2. Despite a Directorate of Professional Standards review, there is no evidence that the MPS identified any shortcoming in their performance in dealing with Jake, consequently no evidence exists of any reflection or remediation of this failing.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 **22nd November 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 and to the following Interested Persons the family of Mr Girton. I have also sent it to the local Director of Public Health who may find it useful or of interest. 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] 29 September 2025 [SIGNED BY CORONER]**