Re : TONY MONTANA DUNCAN DECEASED

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Medical Director of the South London and Maudsley NHS Foundation Trust**
1	**CORONER** I am Alison Hewitt, HM Senior Coroner for the City of London.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** I commenced an investigation into the death of Tony Montana Duncan. The inquest was concluded on the 8th October 2025 when I found that the medical cause of death was: Ia Submersion and my conclusion as to the death was that: The Deceased died as a result of his own deliberate act when his state of mind was adversely affected by acute symptoms of his previously diagnosed mental illness which had probably resulted from a period of non-compliance with medication prescribed to manage those symptoms. The Deceased's death was more than minimally contributed to by his receiving no treatment or support from mental health services following his assessment by the psychiatric liaison team at King's College Hospital's Emergency Department on the 21st June 2024.
4	**CIRCUMSTANCES OF THE DEATH** Tony Duncan suffered long-term mental ill health, with a diagnosis of personality disorder, the symptoms of which were usually managed by prescribed medication. In May 2024, he was exhibiting acute symptoms of

	his underlying condition, and on the 21st June 2024, he presented to his General Practitioner complaining of persisting headache, an acute deterioration of his mental health on a background of non-compliance over previous weeks with his prescribed medication, and suicidal ideation, expressing a plan to jump [redacted] if he did not receive help. The Deceased was sent, by his General Practitioner, to the Accident and Emergency Department of King's College Hospital, with a referral letter requesting assessment of his mental state, possible admission, and medication review. The Deceased was seen later that day by the psychiatric liaison team at the hospital, whose services were provided by the South London and Maudsley NHS Foundation Trust. Following assessment, it was decided that his presentation resulted principally from his social circumstances rather than his mental illness, and he was discharged back to the care of his General Practitioner. The assessment took no account of the Deceased's reported plan to end his life by jumping from a bridge if he did not receive clinical treatment or support. Towards the end of June 2024, the Deceased left his home address, with a selection of his belongings, in a distressed state. At about 03.00 hours on the 4th July 2024, he jumped from [redacted] into the River Thames below. He was carried quickly towards [redacted] by the current and it is likely that he died within a short time of entering the water. The Deceased's body was subsequently found on the 7th July 2024, near to Oyster Wharf mudflats, and his death was formally pronounced at 11.56 hours on that day.
5	**CORONER'S CONCERNS** The evidence I have gathered to date reveals matters giving rise to concern. There were concerns about the manner in which the South London and Maudsley NHS Foundation Trust's Single Point of Access service was operating in the summer of 2024, but I heard evidence which satisfied me that those concerns have since been addressed.

However, the matters of concern set out below persist and, 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. The Deceased presented to the South London and Maudsley NHS Foundation Trust's psychiatric liaison team which was operating within the Accident and Emergency Department of King's College Hospital, with a referral letter from his General Practitioner which sought possible admission and medication review. The Deceased was known to the Trust and he had been the subject of a safeguarding referral and a self-referral shortly before his attendance at the hospital. From the information available to the psychiatric liaison team, it was apparent that:

    (i) The Deceased had a chronic and persisting mental health condition which was usually controlled by medication but which, when not controlled, could give rise to suicidal ideation; he had previously been helped by periods of detention / voluntary admission to hospital,

    (ii) By May 2024, there was evidence that he was suffering an acute deterioration in his mental health which he subsequently reported was because he had not been properly compliant with his prescribed medication for a number of weeks, and

    (iii) The Deceased recognised the deterioration in his mental health, that he was suffering specific suicidal ideation relating to jumping from London Bridge, and that he needed help from mental health services, including by voluntary admission to hospital; he sought help by making a self-referral to the Trust via the Single Point of Access service and by attending his GP and the hospital.

2. When the Deceased attended the hospital, the Accident and Emergency team's triage notes included express reference to his specific suicide plan and attached the GP's letter of referral. The Deceased was then assessed by a psychiatric liaison nurse who

concluded that his presentation was as a result of psycho-social stressors rather than mental illness; she was not concerned about the risk of suicide because he had no plan or intent; and she referred the Deceased to the homelessness team and discharged him back to the care of his GP. The nurse did not take any steps to review the Deceased's medication or consider admission, or escalate these matters to a doctor, nor did she involve the Crisis or Home Treatment teams for follow up / immediate safeguarding. Despite there being a recognised risk to self and to others, both of which the Deceased himself said he could not control, there is no evidence of any risk assessment documentation being completed.

3. The Deceased was subsequently seen in the Accident and Emergency Department by a Social Worker from the homelessness team. The Deceased insisted that he was not homeless and that he had attended the hospital for help with his mental health, without which he would jump from London Bridge. The Social Worker immediately passed this information to members of the psychiatric liaison team who he found, together, in their office. Subsequently, whilst still in the department, the Deceased became agitated and abusive, which behaviour was a recognised aspect of his behaviour when he was unwell. It seems he later left the department and/or was escorted out as he was being abusive; the records show that at least one member of the psychiatric liaison team was aware of this development but took no action to prevent the Deceased from leaving or to encourage him to stay in order to re-assess him, nor to alert the Crisis and/or Home Treatment teams, the GP, or the Deceased's family as to the situation.

4. Following the report of the Deceased's death, South London and Maudsley NHS Foundation Trust's own review highlighted various concerns about the operation of its Single Point of Access service but neither that review, nor the evidence provided to the inquest from the Consultant Psychiatrist who was responsible for the psychiatric liaison team in King's College Hospital, identified any concerns about the management of the Deceased by the psychiatric liaison team on the 4th July 2024. This may suggest that there were

	systemic as well as operational factors which led to the Deceased not receiving the help and support he needed on the 4th July 2024.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths by addressing the concerns set out above and I believe 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 the 10th December 2025**. I, as 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 Interested Persons and other organisations listed below which may find it useful or of interest: The Mother of Tony Duncan, and King's College Hospital NHS Foundation Trust. I am also under a duty to send the Chief Coroner a copy of your response. 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 by the Chief Coroner.
9	**15th October 2025** **Alison Hewitt**