Coroner Service
West Sussex, Brighton & Hove

Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** Mr Wes Streeting MP, Secretary of State for Health and Social Care
1	**CORONER** I am Joseph TURNER, Area Coroner for the coroner area of West Sussex, Brighton and Hove
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** Alex Ganski sadly died from injuries sustained when he jumped from a bridge [redacted] on 20th July 2024. This was the fifth occasion in three years he had visited the same location with thoughts of self harm. His death was referred to the Coroner Service by Sussex Police and an investigation under s.1 Coroners and Justice Act 2009 was opened on 22nd July 2024. The inquest was held on 19th March 2026. The inquest concluded that Alex took his own life following traumatic events earlier in his life causing depression and long-term suicidal thoughts, leading to the use of illicit drugs. He had suddenly absconded from home that evening whilst under the influence of ketamine and diazepam, having relapsed following a period of addiction support. He was receiving specialist care for his mental health but there had not been fully shared information between the services supporting him, or a clear overall lead, creating a missed opportunity to more closely address the confluence of poor mental health, drug misuse, and resulting risk of self-harm.
4	**CIRCUMSTANCES OF THE DEATH** Alex was 19 but had undergone traumatic events in his teens which led to long term mental health struggles and suicidality. At the time he died he was under the care of the local Trust's Mental Health Assessment and Treatment service, with a Registered Mental Health Nurse as his lead practitioner. Contact had been consistent. He had been misusing cannabis, ketamine and diazepam intermittently for some years, although had latterly ceased the latter two drugs whilst receiving support from the local Drug and Alcohol Wellbeing Network. He had been formally diagnosed with suicidal thoughts, anxiety and depression and his GP had prescribed medication although Alex had ceased taking this some weeks prior to death, with the GP's knowledge. Although he had undergone assistance to reduce drug misuse, he had several relapses. Two weeks before he died this had resulted in the ambulance service attending to him, although he declined to be taken to hospital, contrary to paramedic advice. His drug support network was unaware of and not alerted to this incident. The week before he died he had overdosed on tablets bought on the internet. He appeared to have made a physical recovery but was granted mental health leave by his employer that week. He spent the week at home or on family day trips. His mood was low but there were no immediate concerns. However, he purchased several combined packs of ketamine and diazepam from a local dealer on the Friday and Saturday, despite family attempts to intervene. On the Saturday evening he had indicated willingness to consider a rehabilitation facility in his native Poland but he also made a further drug purchase. Suddenly at around 9.20 he burst out of the house and proceeded to a nearby bridge [redacted], from which he jumped sustaining fatal injuries. This was the fifth occasion in three years he had visited the same location with thoughts of self harm.
5	**CORONER'S CONCERNS**

During the course of the investigation my inquiries 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:
(brief summary of matters of concern)

The evidence disclosed that whilst there were multiple agencies, organisations and healthcare providers who had been treating or triaging Alex's mental and physical health conditions, including his misuse of illicit drugs:

a. There was no – and nationally there appears to be no - policy, guidance or structure which would enable a designated lead, or 'single point of contact' with full oversight of, and (more importantly) authority over, Alex's care – taking particular account of his young age.
b. This represents a 'care gap' and missed opportunity whereby a nominated lead could ensure that each incident, attendance, relapse or overdose was alerted to those other agencies, organisations or providers who would need to know or who may benefit from knowing of the occurrence. And then – critically - directing and assuring the right treatment or long-term intervention to follow.
c. The sharing and updating of information regarding Alex's multiple health and drug issues was fragmented, in the absence of clear, national protocols and requirements as to the informing and alerting of new incidents, treatment, or other change in mental or physical health or addiction.
d. I was encouraged to learn of the Plexus Care Record initiative in this local area (Plexus Care Record) but the evidence was that this is voluntary, and that not all providers or agencies are able or willing to connect or provide their records and share information. Moreover, I heard evidence that this is a local but not national initiative and hence information and record sharing elsewhere may be worse. As such the situation is ameliorated by local changes but appears to be a wider and national issue.

I found that these factors were exacerbated in Alex's case as a vulnerable 19 year old who had clearly been suffering with poor mental health and drug misuse whilst, and since, a child, noting that he lacked the experience and knowledge to successfully advocate for himself, or insight into his own needs.

My further concern is that there was no simple mechanism or designation across the various patient record systems for those who may become involved with Alex, to know of the significant wider and historical health and drug misuse issues, in the absence of his own willingness or ability to fully disclose these at each turn. Especially when he may have been under the influence of substances. This meant repeated opportunities to better address Alex's serious underlying conditions and issues were not taken.

This lack of an easily recognised national designator, shown across systems and records, such as 'person at [serious] risk' gives rise to an incomplete understanding of, and risks a failure to sufficiently enquire into, someone's full condition as and when services become intermittently involved, and creates a risk of further similar deaths.

I add that I am very conscious of the Chief Coroner's guidance to consider what can practically be achieved and not to engage with 'ideal world' scenarios, as well as considering the realistic prospect, including on resource grounds, that this report will be acted upon.

I respectfully see no such barriers as regards the 'lead point of contact'. I recognise information sharing will be subject to data protection and handling, consent, privacy and confidentiality issues, but progress has been made locally within existing resource and I consider that these issues need to be better addressed in the national healthcare context, else they will continue to be barriers to preventing deaths, rather than enablers to save lives.

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 May 21, 2026. 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) Sussex Partnership Foundation Trust Change, Grow, Live (West Sussex Drug and Alcohol Wellbeing Network) South East Coast Ambulance Service 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 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. They may send a copy of this report to any person who they believe 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	Dated: 26/03/2026 [redacted] Joseph TURNER Area Coroner for West Sussex, Brighton and Hove