REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Secretary of State for Health and Social Care,** [redacted]
1	**CORONER** I am Sebastian Naughton, Assistant Coroner, for the coroner area of South 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.
3	**INVESTIGATION and INQUEST** On 24 March 2021 an inquest was opened into the death of Hugh Burgess ("Hugh"), who died aged 38 years as following a self-administered overdose of [redacted] on 5 October 2020. Hugh suffered from longstanding and enduring mental illness with psychotic features, having had many admissions for psychiatric treatment before his death. Hugh was in receipt of a package of community care from a specialist team. Hugh's mental health was significantly exacerbated by intermittent drug and alcohol use. The final hearing of the inquest took place between 1-4 June 2026. The inquest examined (among other things) Hugh's management by the community and hospital teams in the weeks before Hugh's death.
4	**CIRCUMSTANCES OF THE DEATH** Hugh was found deceased at his home [redacted] on the evening of 5 October 2020, police officers having forced entry after concerns were raised by Hugh's father the previous day. In the two months prior to his death, Hugh had relapsed [redacted] use, which resulted in fluctuating but serious deteriorations in his mental health. There were two presentations to the emergency psychiatric teams at hospital following which Hugh self-discharged against medical advice from (i) the emergency department on 8 September 2020, and (ii) from a psychiatric ward on 14

	September 2020. On both of these occasions Hugh had presented with psychosis, and had expressed intent to suicide and / or serious self-harm and also harm to others if he were not admitted.
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) There is no power under the Mental Health Act 1983 ("MHA") to enable health professionals in hospital emergency departments to ensure that individuals who are considered to be in need of urgent admission remain on site pending a formal assessment to determine whether compulsory detention is necessary and appropriate. (2) This means that some patients who present significant risks to themselves and / or to others as a result of their mental illness who cannot be persuaded to remain at hospital cannot be prevented from leaving should they decide to do so unless a police officer can first attend to exercise their emergency powers pursuant to Section 136 of the MHA. (3) In contrast, a patient who has been (voluntarily) admitted for treatment may be detained temporarily pursuant to the "holding powers" of Sections 5(2) or 5(4) of the Mental Health Act 1983 should they have a similar change of heart. (4) The Court heard evidence that there is no robust alternative legal power to enable health professionals to prevent individuals in this cohort from leaving hospital. (5) The Court heard evidence that this is a longstanding and frequently occurring problem which represents a gap in safety.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 **3 July 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: 1. Hugh's family; 2. The Chief Executive of Oxleas NHS Foundation Trust; 3. The National Medical Director, NHS England [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. 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	**8 June 2026**