	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: **1. Mr Ben Travis, Chief Executive, Oxleas NHS Mental HealthTrust, Pinewood House, Pinewood Place, Dartford, Kent DA2 7WG** **2. Mr John Comber, Chief Executive, Royal Borough of Greenwich, Town Hall, Wellington Street, Woolwich, London SE18 6PW**
1	CORONER I am Dr Andrew Harris, Senior Coroner, London Inner South jurisdiction
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	INQUEST On 29th June 2016, I opened an inquest into the death of: **Dr Debrata Sircar, who died on 20th February 2016 in his apartment in Banning Street, Greenwich, Case Ref: 00519-16 (JB).** It was concluded on 22nd September 2016. The court found that the medical cause of death was subdural and intracerebral haemorrhage as a result of a fall, associated with alcohol intoxication. The court concluded his death was an Alcohol Related death.
4	CIRCUMSTANCES OF THE DEATH Dr Sircar had a longstanding alcohol dependency problem. He was psychiatrically assessed on 12th February and found to be unsuitable for home treatment. He had a Mental Health Act Assessment booked for 23rd February, by which time he had died. He suffered depression but at the last assessment did not admit to being suicidal.
5	CORONER'S CONCERNS During the course of the inquest, the evidence revealed a matter giving rise to concern that in my opinion means that there is still a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

	The MATTER OF CONCERN is as follows. – 1. He was at risk from falls, associated with his alcohol abuse and had frequently presented in A&E department with symptoms and injuries associated with intoxication. He was unfit to be treated in the community. There appeared to be no sense of urgency in securing a bed. He was booked for a Mental Health Act (MHA) Assessment 11 days after it was advised he needed hospitalization, by which time he had died. The court was informed the delay related to the unavailability of a local authority MHA practitioner. 2. In the intervening 11 day period there was an absence of an interim care plan, identified in the SUI investigation. Although there were plans for increased contacts in future for interim care for those pending MHA assessment, it was unclear who would take the lead and how a patient would be psychiatrically monitored in that period.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe that the MH Trust and local authority 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 Friday, 2nd December 2016. 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. If you require any further information or assistance about the case, please contact the case officer, [redacted]
8	COPIES and PUBLICATION I have sent a copy of my report to the following Interested Persons: [redacted]. I have also sent it [redacted] (GP) and the Royal College of Psychiatrists, who may find it useful or of interest. 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	[DATE] 7 October 2016 [SIGNED BY CORONER]