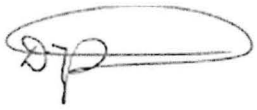
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO THE SECRETARIES OF STATE OF:** **1. The Department of Education** **2. The Department of Health and Social Care** **3. The Department of Culture Media and Sport**
1	**CORONER** I am David Urpeth, Senior Coroner, for the Coroner Area of South Yorkshire West
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 29.11.17, the investigation into the death of **JACK WILLIAM RAMSEY RITCHIE** commenced. The investigation concluded at the end of the inquest on the 4.3.22. The conclusion was a narrative conclusion, copy attached.
4	**CIRCUMSTANCES OF THE DEATH** On the 22.11.17, Jack William Ramsey Ritchie (hereafter "Jack"), [redacted] of a restaurant situated as Lane 193, Nghi Tam Road, Yen Phu Ward, Tay Ho, Hanoi, Vietnam. The evidence was that he[redacted] with the intention of taking him own life. He died of multiple injuries. Jack had suffered a gambling addiction dating back to aged 17, a time when he was still at school.
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 will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – During the inquest, evidence showed:- - That the system of regulation in force at the time of his death did not stop Jack gambling at a point when he was obviously addicted to gambling - The warnings Jack received were insufficient to prevent him gambling

	- The information available to Jack was insufficient to prevent him gambling or to inform him of the help / treatments available - The treatment available and received by Jack was insufficient to cure his addiction – this in part was due to a lack of training for medical professionals around the diagnosis and treatment of gambling addiction - Jack didn't understand that being addicted to gambling wasn't his fault. That lack of understanding lead to feelings of shame and hopelessness which is turn, contributed to him feeling suicidal - That in the time since Jack's death, whilst there have been improvements made in the areas of warnings, information, training and treatment, the evidence showed there were still significant gaps in these areas. One notable gap was the fact that evidence suggested GPs currently have insufficient training and knowledge to deal effectively with gambling problems. This was of particular concern given many gamblers affected are likely to contact a GP as their first attempt to seek help - The evidence was that young people were the most at risk from the harms of gambling yet there was and still appears to be, very little education for school children on the subject. As I said in open court and repeat here, I stress I am not, and would not, attempt to tell government upon what and how they should act or indeed legislate. I issue this preventing future death report in the hope that Government finds the concerns raised informative and of assistance, especially at a time they are considering the whole issue of gambling and its regulation. Indeed, I recall the Director General of Dept of Health and Social Care who gave evidence at the inquest saying that Government was looking to this inquest to learn. I therefore hope this preventing future death report will assist in this regard. I leave the government, as they see fit, to cascade this report to all appropriate government departments, as well as any other organisations, professional bodies or charities working within the arena of problem gambling. I do this as the government are best placed to control or oversee legislation, regulation, education, treatment and support, and to promote any actions around the issue of problem gambling designed to prevent future deaths.
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 2.5.22. 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 all Interested Persons:- 1. Family of Jack Ritchie 2. The Gambling Commission 3. GambleAware 4. GamCare 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, 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	**Dated: 7.3.22**  **SIGNED BY** **DAVID URPETH, SENIOR CORONER SOUTH YORKSHIRE (WEST)**