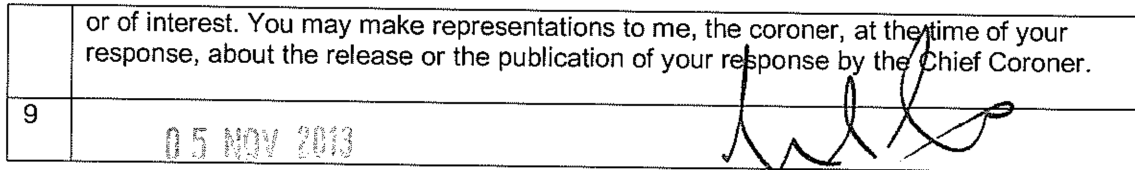
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Department of Health Ministerial Correspondence and Public Enquiries Unit Department of Health Richmond House 79 Whitehall London SW1A 2NS
1	**CORONER** I am Andrew Walker, senior coroner, for the coroner area of Northern District of Greater 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 15th Day of October 2012 I commenced an investigation into the death of Roshen Abbas Ladak-Ebrahim aged 22 years old. The investigation concluded at the end of the inquest on the 1st day of November 2013 concluding on the 4th Day of November 2013. The conclusion of the inquest was a narrative conclusion; the medical cause of death was hanging. Narrative conclusion:- On the 6th September 2012 Roshen Abbas Ladak-Ebrahim was referred by the walk in centre to Barnet Primary Health Care Trust who forwarded the urgent referral to the Brent Assessment and Brief Treatment Team. On the 11th September 2012 a nurse contacted Mr Ladak-Ebrahim and an appointment was made for an assessment on the 20th September 2012 the nurse who spoke to Mr Ladak-Ebrahim had spoken to his mother on the 10th September 2012 and was told Mr Ladak-Ebrahim's history including the episode of self-harm and raised her concerns. On the 20th September 2012 Mr Ladak-Ebrahim was taken by his father for his assessment. Mr Ladak-Ebrahim was prescribed medication by a doctor following a multi-disciplinary meeting after Mr Ladak-Ebrahim was assessed by the nurse. Mr Ladak-Ebrahim was not seen by a doctor and no formal follow up meeting was arranged. Mr Ladak-Ebrahim contacted his GP on the 10th October 2012 and the GP sent a fax to Brent Assessment and Brief Treatment Team requesting an urgent assessment. On the 11th October 2012 at 13.29 hrs a nurse contacted Mr Ladak-Ebrahim by telephone and it is likely at that time he was at an immediate risk of harming himself. The Nurse wanted Mr Ladak-Ebrahim to be seen by a doctor but was told that no doctor was available and a referral was made to the Home Treatment Team. The referral to the Home Treatment Team was not accepted until the nurse spoke to the Home Treatment Team the next day. Mr Ladak-Ebrahim had been found having hanged himself at his home on the evening of

	the 11th October 2012.
4	**CIRCUMSTANCES OF THE DEATH** Mr Ladak-Ebrahim had contact with a number of health care professionals and was living at home with his mother. Had Mr Ladak-Ebrahim's mother been told that he was at an immediate risk of self-harm she would have ensured that he was not left alone.
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. – Consideration to be given to issuing guidance when assessing risk of self-harm. The suggestion at the inquest was to firstly assess and record whether there is an immediate risk of self-harm. If there is no immediate risk of self-harm then the assessment should focus on whether there are any thoughts of self-harm, (recording frequency, duration, intensity etc). Whether there is a plan, (recording the details of the plan or plans, etc) and whether there is an intention to end life. Whether the individual is vulnerable to acting on impulse and any past history. The use of high, medium and low risk were considered unhelpful when assessing risk of self-harm. Consideration to be given to giving guidance to health care professionals on the steps that should be taken to ensure that a patient is kept safe by those looking after the patient. In particular informing those looking after a patient that the patient should not be left alone where there is a concern that the patient is at risk of harming themselves. Evidence heard at the inquest suggested that there was some confusion over whether this advice would breach a patient's confidentiality. Consideration to be given to guidance whereby a doctor working in the community mental health agencies is required to have a consultation with a patient before prescribing medication that carries an increased risk of self-harm when first prescribed and arranges to see the patient again to assess the effect of the medication.
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 Wednesday 2nd January 2013. 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 Solicitors representing the Mental Health Trust, and Mr Ladak-Ebrahim's mother. Mr Ladak-Ebrahim's father and the nurse involved in Mr Ladak-Ebrahim's care. 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	05 NOV 2013