Regulation 28: Prevention of Future Deaths report

Stephen Anthony WARD (died 28.02.14)

	THIS REPORT IS BEING SENT TO: **1. Ms Wendy Wallace** **Chief Executive** **Camden & Islington NHS Foundation Trust** **4th Floor, East Wing** **St Pancras Hospital** **4 St Pancras Way** **London NW1 0PE**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 06.03.14, I commenced an investigation into the death of Stephen Anthony Ward, aged 41 years. The investigation concluded at the end of the inquest yesterday. I made a determination that Stephen Ward took his own life by hanging.
4	**CIRCUMSTANCES OF THE DEATH** Mr Ward had a long history of depression and other mental health problems, but he deteriorated in 2013, following the death of his mother at the hands of his step father, and his step father's suicide by hanging.

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. Mr Ward had a great deal of input from a variety of mental health services, including daily visits/telephone calls from the South Camden Crisis Resolution Team in the period immediately leading up to his death. When he did not attend the South Camden Recovery Centre at Jules Thorn, or respond to telephone messages or an unannounced crisis team visit on Thursday, 27 February (the day before he was found hanging by a close friend), members of the crisis team were worried. They did not immediately ask police to conduct a welfare visit, which I appreciate was a matter of clinical judgement. They were influenced in particular by the fact that their visit was not scheduled and so he might have been out, as he had been on a previous occasion. However, at around 7.30pm on Thursday, 27 February, a member of the crisis team placed a call to police asking for a welfare check to be carried out. What concerns me is that, when the police did not call back within an hour or two, nobody from the crisis team followed this up with the police. The next contact was at around 8.15am on the morning of Friday, 28 February, when the police rang the crisis team to say that they were outside Mr Ward's building and could not locate his flat. In fact, Mr Ward's friend had by this time found him hanging. Mr Ward did not have any personal contact with anyone after Tuesday, 25 February, so by the time the alarm was raised on Thursday evening, he might well have already died. However, he might not. In any event, following up with the police might be critical for another person in his position. It seems that the team would benefit from a clear protocol about the required action once police have been contacted and I invite you to consider this.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I

	believe that you and 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 25.07.14. 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 following. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales • [redacted] brothers of Stephen Ward • [redacted] friend of Stephen Ward 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 29.05.14