REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) Chief Executive - Barnet, Enfield and Haringey Mental Health NHS Trust** (BEH)
1	**CORONER** I am R Brittain, Assistant Coroner for Inner North 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** The investigation into the death of Michael Harry WORRALL, aged 28, was opened on 20 October 2013 and concluded at the end of the inquest on 11 April 2014. The conclusion of the inquest was narrative (Copy attached).
4	**CIRCUMSTANCES OF THE DEATH** Mr Worrall had longstanding mental health issues, which originated during his teenage years. In 2012 he was admitted to a medium-secure forensic unit, under the care of BEH. He underwent psychological assessment during this admission. The recommendation of the psychologist was that, on discharge, Mr Worrall should have ongoing psychological treatment. In 2013 Mr Worrall was transferred to the low-secure unit at Avesbury House, also under the care of BEH. The intention was that this would be a short admission in order to facilitate his discharge to community services. Mr Worrall's admission was extended following an initial decline in his mental health and owing to concerns regarding his concordance with medication administration. This resulted in a three month admission to Avesbury House. During this time Mr Worrall did not have access to psychological treatment. I heard evidence at the inquest from [redacted] Consultant Forensic Psychiatrist at Avesbury House, that the waiting list for such input in this setting is approximately three months. Mr Worrall was discharged to community services in July 2013. He did access psychological therapy in this setting. He also had ongoing review by his community psychiatric nurse. Despite this contact and an apparent stabilisation in his mood, Mr Worrall unfortunately died after falling from a bridge in October 2013. There was no evidence that the lack of psychological treatment at Avesbury House contributed to Mr Worrall's death.
5	**<u>CORONER'S CONCERNS</u>**

	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. – (1) The limited availability of psychological therapy at Avesbury House could be significant for patients who, prior to transfer there, were receiving such input. The concern was raised by Mr Worrall's family, which I share, that this period of discontinuation of psychological input might have adverse consequences on subsequent discharge into the community.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe the you, as the Chief Executive of BEH, 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 17 June 2014. 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 (a) Mr Worrall's family and (b) The Care Quality Commission. 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	**22 April 2014** **Assistant Coroner R Brittain**