Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
29 Wood Street,
Barnet EN5 4BE

Telephone 0208 447 7680
Fax 0208 447 7689

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Department of Health Richmond House 79 Whitehal 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 the 16th August 2013 I opened an inquest toughing the death of Farres Ikken , 34 years old. The inquest concluded on the 4th June 2014. The conclusion of the inquest was "open", the medical case of death was 1a Hypoxic Brain Injury, 1b Hanging
4	**CIRCUMSTANCES OF THE DEATH** Farres Ikken was arrested on the 7th August 2013 at his home and brought to Wembley Police Station. At the time of his arrest he stated that he wanted to kill himself. Mr Ikken was visited by the Mental Health Crisis Team in his cell at the police station. Mr Ikken was not sectioned under the Mental Health Act. Mr Ikken was taken to Hendon Magistrates Court and was bailed and taken to Park Royal Centre for Mental Health on the 8th August 2013 where he was assessed as not falling within a category of patient that could be treated at the Centre . Mr Ikken was discharged on the 9th August 2013 for follow up by his GP and for a referral from his GP to the psychological service. Mr Ikken left the building and shortly after hanged himself in the grounds of the hospital within sight of the unit he had just left.

Her Majesty's Coroner for the Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

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. – That staff at the hospital could not themselves, on discharge, refer Mr Ikken to community psychology services.
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 Tuesday 26th August 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 the following Interested Persons;- Members of Mr Ikkens family, Central and North West London NHS Foundation Trust 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	**2nd July 2014**