Regulation 28: Prevention of Future Deaths report

Andrew Elliot FROST (died 25.09.14)

	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 30 September 2014, I commenced an investigation into the death of Andrew Elliot Frost, aged 34 years. The investigation concluded at the end of the inquest yesterday. I made a determination that Andrew Frost took his own life.
4	**CIRCUMSTANCES OF THE DEATH** Mr Frost jumped in front of an underground train early in the morning on 25 September 2014.

	The day before his death, he had three separate encounters with the authorities, the first with police; the second with police, paramedics, general practitioner and crisis team; the third with police and paramedics. On each occasion, concern was shown for Mr Frost and attempts were made to assist him.
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 second encounter on 24 September 2014, whilst police and paramedics were at Mr Frost's home, Mr Frost and his general practitioner spoke on the telephone. The general practitioner was worried about Mr Frost and made an immediate referral to the Islington Crisis Team at Highgate Mental Health Centre. He was told that the team did not have sufficient resources to go out to see Mr Frost that afternoon, but that someone would ring him. 1. There was no shared understanding between the crisis team and the GP about what the crisis team could and could not do. The GP thought that the crisis team's telephone call would include a conversation sufficiently detailed to allow the crisis team to decide whether to conduct a mental health act assessment that afternoon, whereas the crisis team simply intended to arrange an appointment for the following day. The GP regarded the crisis team as an emergency service, which the team leader told me in court is not the case. It seems that this GP, his partners, and the other general practitioners who refer patients to crisis teams, would benefit from a very specific piece of training and education from the crisis team about their service, including its limitations. 2. The crisis team's records did not reflect some valuable information that was passed to them. For example, that police and paramedics were with Mr Frost at the time of the GP's call. This information was communicated by the GP and by Mr Frost's partner. If the crisis team had considered

	this information, they could have advised Mr Frost's partner he should tell the paramedics that the crisis team were not coming out that day, which may have assisted paramedics' decision making. 3. The pager messaging service used by the crisis team simply takes the name of the patient and a telephone number to call, nothing more. This means that valuable time was wasted by the crisis team, trying to track down the police officer who had rung to find out more detail, most especially Mr Frost's address. This is time that could be used treating patients. I did not hear evidence that led me to conclude that different action by healthcare professionals on 24 September would have changed the outcome for Mr Frost, but it might for someone else.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 11 May 2015. 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 • Care Quality Commission for England • Professor Dame Sally Davies, Chief Medical Officer for England • [redacted], Mr Frost's partner 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** 12.02.15