Regulation 28: Prevention of Future Deaths report

Mark Patrick DANIELS (died 27.11.14)

	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 3 December 2014, I commenced an investigation into the death of Mark Daniels, aged 56 years. The investigation concluded at the end of the inquest earlier today. I made a narrative determination, which I attach.
4	**CIRCUMSTANCES OF THE DEATH** Mr Daniels hanged himself following several contacts with South Camden Crisis Response and Resolution Team. There was an agreement that he be admitted to Rivers Crisis House, but this never took place.

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. You will see from the determination attached, that I found there was a failure by the crisis team: - to visit Mr Daniels twice a day, despite a plan so to do; - to record why twice daily visits were not attempted; - to communicate within the team and with the two crisis houses; - to progress the referral to a crisis house promptly; - to consider hospital admission, despite the fact that Mr Daniels was known to have made several suicide attempts; had told staff he did not feel safe at home; was observed to be keeping a rope at home; told staff he would kill himself, albeit not immediately; said he wanted to be in a contained environment; and there was apparently no prospect of prompt admission to crisis house. I gained the impression of a lack of cohesion and clinical direction.
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 31 July 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], sister of Mark Daniels. 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** 1 June 2015