## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**(1) Wendy Wallace, Chief Executive, Camden and Islington NHS Foundation Trust (CANDI)** |
| 1 | **CORONER**<br><br>I am R Brittain, Assistant Coroner for Inner North London |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>Keith Gallimore died on 4 December 2014, aged 30. The medical cause of death was the combined toxic effects of heroin and cocaine. The inquest into his death was heard on 1 May 2015, at which I recorded an open conclusion. It was not possible to establish suicidal intent to the necessary standard of proof, nor was it possible to determine that the death was accidental. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Mr Gallimore had a background history of complications following appendicectomy, along with significant psychological stressors, related to his social situation. This resulted in him attending his General Practitioner, in order to seek help for anxiety and depression. He was referred to the 'iCope' service provided by CANDI and consulted with a clinical psychologist in November 2014.<br><br>Mr Gallimore discussed plans he had made for committing suicide at this consultation, which prompted referral to the 'Crisis Team' within the same Mental Health Trust. A referral note was made in the 'Rio' electronic medical records which could be accessed by both iCope and the Crisis Team. This set out a summary of the psychologist's consultation, which was fully documented in iCope's own electronic record system. This system was not accessible by the Crisis Team but a request could be made to iCope for the full documentation to be copied into the Rio records.<br><br>I heard evidence from the clinical lead of iCope that he was unclear as to why their records were not accessible by others within CANDI but considered that there may be issues regarding the potentially sensitive nature of these notes. He also set out his expectation that notes made by iCope should be duplicated in the Rio notes.<br><br>A member of the Crisis Team reviewed Mr Gallimore a day after the referral was made, at which time he did not report any ongoing plans for suicide, nor was he thought to have a |

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| | mental health diagnosis. He was discharged from the Crisis Team at this point (with ongoing plans having already been made for follow-up within CANDI).<br><br>Unfortunately, he was found deceased at his home address on 4 December 2014. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) I am concerned that potentially important information, documented by a service provided by CANDI, is not accessible by other services within the same Trust, without a proactive request being made. It was not clear why this restriction is in place, nor what steps could be taken if information was required in an 'out-of-hours' setting, at which time the iCope service would not be available to copy notes to Rio.<br><br>Although there was no evidence that, had the iCope notes been available to the Crisis Team, the outcome of Mr Gallimore's case would have been different, I am concerned that future deaths could result because of this issue. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe that the addressee, has the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 6 July 2015. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the Gallimore family.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **11 May 2015**<br>**Assistant Coroner R Brittain** |