Regulation 28: Prevention of Future Deaths report

Andrew James AITKEN (died 10.08.14)

	THIS REPORT IS BEING SENT TO: **1. Dr Kevin Cleary** **Medical Director** **East London NHS Foundation Trust** **Trust Headquarters** **9 Alie Street** **London E1 8DE** **2. Dr Steve Ryan** **Medical Director** **Barts Health** **Royal London Hospital** **Whitechapel Road** **London E1 1BB**
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 13 August 2014 I commenced an investigation into the death of Andrew (also known as James) Aitken, aged 30 yrs. The investigation concluded at the end of the inquest on 11 November 2014. I made a determination that Mr Aitken took his own life.

4	**CIRCUMSTANCES OF THE DEATH** Andrew Aitken was admitted to the Royal London Hospital on 10 June 2014, having taken a drug overdose. He was treated medically, seen by psychiatrists on three separate occasions and discharged on 16 June. Two months later he was found at home, having died of amitriptyline toxicity, not having accessed any mental health care in the meantime.
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. 1. When Mr Aitken was admitted to hospital on 10 June 2014, his girlfriend brought in the remainder of the tablets he had taken, hoping to assist those treating him. [redacted] told me that a nurse took the tablets from her, of which there were still many remaining, and simply left them on the hospital bedside cabinet next to Mr Aitken. 2. Mr Aitken had been admitted to Prestwich Hospital Psychiatric Hospital when he was 16 years old. When he was admitted on 10 June 2014, no consideration was given to asking for any record of that inpatient stay. That was some 14 years earlier and may not have yielded anything useful but, as Mr Aitken was not registered with a general practitioner, it was the only source of history from healthcare professionals. 3. The junior psychiatrist discharging Mr Aitken did strongly advise him to register with a GP and then to seek referral to mental health services, but it did not occur to her to refer him direct to the community mental health team, given that he had no GP. 4. I was told that Mr Aitken was discharged from hospital in gown and socks, with no clothes or shoes. I understand that East London Trust has now decided to undertake a serious incident review, but I am concerned that [redacted] has already written to the Royal London Hospital, has received no response to that letter, and has been told that there is no ongoing investigation into her complaint.

6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you and your organisations 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 February 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 • [redacted], Andrew Aitken's mother • [redacted], Andrew Aitken's former partner • [redacted], psychiatry liaison consultant, Royal London • [redacted], serious incident reviewer, East London 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** 15.12.14