Regulation 28: Prevention of Future Deaths report

Matthew Marc GROOM (died 15.06.15)

	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** **2. Dr Richard Jennings** **Executive Medical Director** **The Whittington Hospital NHS Trust** **Magdala Avenue** **London N19 5NF**
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 25 June 2015, commenced an investigation into the death of Matthew Marc Groom aged 36 years. The investigation concluded at the end of the inquest earlier today. I made a narrative determination, a copy of which I attach.

4	**CIRCUMSTANCES OF THE DEATH** Matthew Groom stood in front of a lorry following seven hours in the emergency unit of the Whittington Hospital, where he was seen by emergency medicine staff from Whittington Health Trust and mental health staff from Camden and Islington Trust.
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. Most importantly, Matt Groom waited four hours in the emergency unit before he saw a mental healthcare professional for the first time. I heard that, at the time in these circumstances, it was not possible for a triage nurse to arrange for immediate mental health assessment. 2. Diazepam was prescribed but never administered. 3. The mental health nurse who then saw him did not consider what action to take if he should suddenly decide to leave, most particularly given that she felt unable to conclude the assessment without waiting for a doctor to come in from home to assist. 4. When Matt did leave the department, the assessing doctor asked the nurse to call the police, but neither doctor nor nurse considered seeking urgent assistance from hospital security, given that they were by now both of the view that he would probably now have to be detained under section of the Mental Health Act. 5. The nurse who then contacted the police did not then convey this to them, but requested a welfare check that would be satisfied by knowing he was with a family member.
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 January 2016. 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 • Metropolitan Police Service • [redacted] Matthew's parents 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** 12.11.15