The Coroners Service for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
29 Wood Street,
Barnet EN5 4BE

Senior Coroner Andrew Walker Esq.
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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1.Department of Health Richmond House 79 Whitehall London SW1A 2NS 2 Royal College of Psychiatrists, 21 Prescot Street, London, E1 8BB
1	**CORONER** I am Andrew Walker, senior coroner, for the coroner area of Northern District of Greater London
2	**CORONER'S LEGAL POWERS** 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** On the 27th Day of November 2016 I opened an investigation touching the death of Jonathan Daniel Zucker , 49 years old. The inquest concluded on the 2nd day of May 2017. The conclusion of the inquest was "consequence of a treatment resistant depression", the medical case of death was 1a Cerebral Hypoxia 1b Hanging.
4	**CIRCUMSTANCES OF THE DEATH** On the Twenty –seventh of November 2016 Jonathan Daniel Zucker was found at his home having hanged himself with a length of rope from banisters. Mr Zucker was suffering with a treatment resistant mental health illness and had received both private and NHS treatment.
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. – That there was no requirement for ,or system for, a lead clinician from either the private or NHS treating teams to oversee and coordinate the care provided to Mr Zucker by the private and NHS mental health services.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 Monday 21st August 2017. 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 Chief Coroner and to the following Interested Persons;- Representatives of the family. 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 coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**26-6-2017**