Coroner ME Hassell
HM Senior Coroner
Inner North London

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: [redacted] Group Director of Housing Care & Support One Housing Group 100 Chalk Farm Road London NW1 8EH
1	**CORONER** I am: Assistant Coroner Sarah Bourke Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
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 21 November 2018 Assistant Coroner Brittain commenced an investigation into the death of Brian Goodman (aged 76 years). The investigation concluded at the end of the inquest on 12 March 2019. The conclusion of the inquest was that: Mr Goodman hanged himself on 9 November 2018. The medical cause of his death was: 1a suspension

	I recorded a short-form conclusion of suicide.
4	**CIRCUMSTANCES OF THE DEATH** Mr Goodman had a diagnosis of emotionally unstable personality disorder with depression. He had attempted to end his life on a number of occasions. A number of methods had been used in these attempts, including hanging. In 2016, he moved into [redacted] which is managed by One Support. In addition to support from One Support, Mr Goodman was a regular user of services provided by MIND in Camden. Mr Goodman had frequent contact with One Support staff who noted that he had a tendency to ruminate about past events and would express thoughts of wanting to "end it all". In May 2018, MIND employees became aware that Mr Goodman had tied a scarf around his neck with the intention of hanging himself but had not gone through with this. One Support staff were informed. The matter was discussed with Mr Goodman. The rail was moved from Mr Goodman's wardrobe as it was recognised to be a potential ligature point. On 8 November 2018, MIND informed workers at One Support that Mr Goodman had told a volunteer that he bought a rope in order to hang himself. This was discussed with Mr Goodman who agreed that his room could be searched. No rope was found. On 9 November 2018, staff found Mr Goodman hanging from the door closing mechanism to his room during the morning welfare check.
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 could 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) Mr Goodman expressed thoughts of hanging himself in May and November 2018. He also had a history of attempting suicide by hanging. (2) Whilst Mr Goodman's wardrobe rail was recognised to be an obvious ligature point and removed in May 2018, no steps were taken to change the door closing mechanism in his room which could also be used as a ligature point. (3) The same type of door closing mechanisms continue to be used in One Support properties.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 15 June 2019. 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: [redacted] (daughter) 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.
	H.M. CORONER INNER NORTH LONDON **Sarah Bourke** **Assistant Coroner** **17 April 2019**