# Regulation 28: Prevention of Future Deaths report

## Nimo YOUNIS (died 25.01.19)

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| | **THIS REPORT IS BEING SENT TO:**<br><br>1. **Ms Angela McNab**<br>**Chief Executive**<br>**Camden & Islington NHS Foundation Trust (C&I)**<br>**4th Floor, East Wing**<br>**St Pancras Hospital**<br>**4 St Pancras Way**<br>**London NW1 0PE**<br><br>2. **Commissioner Cressida Dick**<br>**Metropolitan Police Service (MPS)**<br>**6th Floor, New Scotland Yard**<br>**Victoria Embankment**<br>**London SW1A 2JL** |
| 1 | **CORONER**<br><br>I am: Coroner ME Hassell<br>Senior Coroner<br>Inner North London<br>St Pancras Coroner's Court<br>Camley Street<br>London N1C 4PP |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 4 February 2019, one of my assistant coroners, William Dolman, commenced an investigation into the death of Nimo Younis aged 37 years. The investigation concluded at the end of the inquest on 18 November 2019. The jury made a narrative determination at inquest, a copy of which I attach. |

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| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Nimo Younis was detained in the psychiatric intensive care unit of St Pancras Hospital under section 3 of the Mental Health Act. She was granted unescorted leave from Ruby Ward at 6pm on 24 January 2019, with an agreement to return at 8pm. She did not.<br><br>The following day between 6.35pm and 8.48pm (when she was found at the home of a friend by police), she hanged herself. |
| 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>When Nimo Younis did not return to the ward as agreed at 8pm on 24 January, her absence was quickly noted. From 9.32pm that evening, a series of telephone conversations took place between Camden & Islington NHS Trust (C&I) Ruby Ward staff and the Metropolitan Police Service (MPS), but there was police classification of a high risk missing person and consequent action only at approximately 5pm the following day. Thus she was not found before she hanged herself.<br><br>1. C&I ward staff did not have a proper understanding of what action the MPS would take in what circumstances, following the report of a patient absent without leave.<br><br>2. C&I ward staff did not have a proper understanding of what action the MPS required others to take in order to prompt the police to progress the matter further.<br><br>3. C&I ward staff did not have a practical plan as to how to take that action with the resources at their disposal.<br><br>4. C&I ward staff did not have a proper understanding of what key information they needed to provide the MPS in order to trigger a police missing person enquiry, or to escalate an existing enquiry.<br><br>5. C&I ward staff did not promptly or fully utilise the significant potential of their patient's friends, who were ultimately the route by which Nimo Younis was found, and who would certainly have acted sooner if they had appreciated the lack of action being taken - whatever the reason for that lack of action. |

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| | 6. The MPS decision makers, particularly the night time duty inspector, did not have all the information that the MPS held when they were making decisions. Evidence was given that this was a resourcing issue on that particular night and of course it is difficult to legislate for that, but creative thinking may be utilised to address such an issue.<br><br>7. Whether or not there is agreement between the MPS and any trust about who should be doing what, there must be a clarity about what information the MPS needs in order to make the best decisions and what action the MPS will then take.<br><br>If the situation preceding Nimo Younis's death is to be avoided in the future, the MPS needs to set out its position simply and clearly, and the trust needs to ensure that all relevant staff truly understand the position and are equipped to act accordingly.<br><br>This needs to include a recognition that different organisations may have different definitions of the same terms. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion, action should be taken to prevent future deaths and I believe that you have 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 20 January 2020. 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 following.<br><br>• HHJ Mark Lucraft QC, Chief Coroner of England & Wales<br>• [redacted] friend of Nimo Younis and interested person<br><br>I am also under a duty to send the Chief Coroner a copy of your response. |

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| | 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**<br><br>20.11.19 |
| | **SIGNED BY SENIOR CORONER**<br><br>  |