MR G IRVINE
ACTING SENIOR CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Ministerial Correspondence and Public Enquiries Unit Department of Health and Social Care, 39 Victoria Street, London, SW1H 0EU** [redacted] 2. [redacted] **Chief Executive Officer, Camden and Islington NHS Foundation Trust, St. Pancras Hospital, 4 St Pancras Way, London, NW1 0PE** [redacted]
1	**CORONER** I am Graeme Irvine, acting senior coroner, for the coroner area of East 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 28th September 2020 I commenced an investigation into the death of Mr Stuart Tokam. The investigation concluded at the end of the inquest on 12th August 2021. The conclusion of the inquest was Mr Tokam died from 1a Hanging A short-form conclusion of Suicide was arrived at.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a documented history of depressive illness and had previously made two attempts to take his own life.

	On 9th July 2020 a referral was made on Mr Tokam's behalf to the Camden and Islington NHS Trust - CDAT – Complex Depression, Anxiety and Trauma Service. Despite the details of the referral specifically outlining acute concerns regarding the acuity of Mr Tokam's risk of suicide, no clinical assessment was arranged for the patient until 5th October 2020. Mr Tokam hanged himself from railings in the car park of Dalaman Airport, Turkey on 18th September 2020.
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. There was an unacceptable delay in arranging a clinical assessment of Mr Tokam. 2. There appears to have been no process in place to triage the acuity of a referral and expedite a clinical assessment where necessary.
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 **8th October 2021**. 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 the family of Mr Tokam and the CQC. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**[DATE]** 13th August 2021 **[SIGNED BY CORONER]**