Regulation 28: Prevention of Future Deaths report

Thiago Araujo (died 5th February 2020)

	THIS REPORT IS BEING SENT TO: Camden and Islington NHS Foundation Trust 4 St Pancras Way, London NW1 0PE Ministerial Correspondence and Public Enquiries Unit Department of Health and Social Care 39 Victoria Street London SW1H 0EU United Kingdom Secretary of State for the Home Department 2 Marsham Street London SW1P 4DF United Kingdom public.enquiries@homeoffice.gov.uk The Commissioner of Police of the Metropolis Metropolitan Police Service New Scotland Yard Broadway London SW1H 0BG new.scotland.yard@met.police.uk AMHP Service Manager Camden Reception 5 Pancras Square London N1C 4AG Royal Mail Legal Services 6a Eccleston Street, Victoria, London, SW1W 9LT, England
1	**CORONER** I am:

	Assistant Coroner Graeme Irvine Poplar Coroners Court 127 Poplar High St, Poplar, London E14 0AE
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 the 7th of February 2020 I opened an investigation touching upon the death of Thiago Araujo, aged 26 years old. I opened an inquest on the 14th February 2020. The inquest concluded on the 28th of January 2021. The conclusion of the inquest was a narrative conclusion; *"Mr Thiago Vieira Strazzeri De Araujo deliberately ingested sodium nitrate on 5 February 2020 which caused his death. Mr Araujo had been diagnosed with an emotionally unstable personality disorder which exhibited itself in; a preoccupation with death, emotional dysregulation, high risk behaviour, and at times - suicidal thoughts. Mr Araujo received community psychiatric care at the time of his death, he had disengaged from that care and consequently, there is no contemporary medical assessment of his mental state. In the days prior to his death he was observed by his family to suffer from psychotic delusions. It is not possible to satisfactorily determine his state of mind at the time of his death"* The medical cause of death was; 1a sodium nitrate or nitrite toxicity

4	**CIRCUMSTANCES OF THE DEATH** On 5 February 2020 Mr Thiago Araujo was found deceased at his mother's home address. It was determined that Mr Araujo had consumed sodium nitrite which caused his death. At the time of his death Mr Araujo was under the care of the Camden and Islington NHS trust community recovery team.
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. On 24 January 2020 Mr Araujo had discharged himself from psychiatric inpatient care he was to be supervised by the Camden and Islington NHS trust crisis team. Mr Araujo failed to engage with the crisis team and following a meeting on 30 January 2020 the crisis team closed Mr Araujo's referral. In the course of this closure no arrangements were made to address the risks presented by Mr Araujo. 2. Following Mr Araujo's death it has become clear that the closure of his case by the crisis team was not permanent, and had Mr Araujo or his family approached the crisis team to reopen his case, steps could have been taken to reinstate crisis team support. Mr Araujo's family were unaware of this facility. 3. Family and carers of patients diagnosed with emotionally unstable personality disorder do not receive support or education upon management of this diagnosis from Camden and Islington NHS Trust, unless the patient has been received for treatment by the personality disorder service. 4. By 4 February 2020 the Camden and Islington community recovery team identified an acute risk of suicide in Mr Araujo, faced with his non-compliance with community treatment they considered an admission into inpatient care. No actions were taken to affect this plan. 5. In evidence the community recovery team indicated that a factor in their inaction was the knowledge that arranging a section 135 mental health act 1983 warrant and assessment would take two weeks. Such an assessment requires actions by an approved mental health practitioner from the local authority, two section 12

	mental health act approved doctors, the assistance of the Metropolitan police and the local magistrates court to secure a warrant. A delay of 14 days in securing a mental health act assessment is in my opinion unacceptable. 6. In the days leading to Mr Araujo's death his family became aware that he had made an online purchase of sodium nitrite which was to be delivered to his father's home. Despite raising these issues with Camden and Islington NHS trust, the Metropolitan police and employees of the post office there appeared to be no process available to the family to escalate their concerns to prevent delivery of this package.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that your organisation has 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 26th March 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 following. • Thiago Araujo's 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	DATE 29th January 2020 SIGNED BY ASSISTANT CORONER GRAEME IRVINE