Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
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Barnet EN5 4BE

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Department of Health Richmond House 79 Whitehal London SW1A 2NS
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 25th June 2012 I opened an inquest touching the death of Henry Marsh , 30 years old. The inquest concluded on the 10th June 2014. The conclusion of the inquest was "Suicide", the medical case of death was 1a Polydrug Intoxication
4	**CIRCUMSTANCES OF THE DEATH** Henry Marsh had multiple diagnoses including Emotionally Unstable Personality Disorder , Depression, Post Traumatic Stress Disorder, Alcohol Dependence and Poly Substance Abuse. Mr Marsh was under the care of the Home Treatment Team at the time of his death. On the 18th July 2012 Mr Marsh failed to attend his appointment with his psychologist who raised concerns with Mr Marsh's father who found Mr Marsh unresponsive on his bed at his home.
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. – The numbers of patients that the Home Treatment Team have under their care were too many and there were difficulties in holding effective multi –disciplinary meetings when

	carrying such a large caseload.
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 Tuesday 26th August 2014. 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;- Members of Mr Marsh's family, North Middlesex University Hospital Trust 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	**2nd July 2014**