	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Barnet, Enfield and Haringey Mental Health NHS Trust**
1	**CORONER** I am John Taylor, assistant coroner for the coroner area of the 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 18 June 2014, the senior coroner commenced an investigation into the death of Huseyin Hasan Erdogan, aged 26. The investigation concluded at the end of the inquest on 9 February 2015. The conclusion of the inquest was: Medical cause of death: 1a. Cerebral hypoxia; 1b. Hanging and 2. Psychosis and depression. Narrative conclusion summarised: Failure by the mental health practitioners of Barnet, Enfield and Haringey Mental Health NHS Trust to conduct, and to act upon, a fully-informed assessment of the deceased's mental state, which contributed to his death, in that it resulted in no steps being taken by them to prevent his hanging.
4	**CIRCUMSTANCES OF THE DEATH** Mr. Erdogan hanged himself on 4 June 2014 and, on 13 June 2014, died of cerebral hypoxia, which resulted directly from the hanging.
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 action plans to which I refer below accompanied my copy of the Root Cause Analysis Investigation Report approved by Barnet, Enfield and Haringey Mental Health NHS Trust on 17 September 2014. The Report was prepared following the Trust's investigation into Mr. Erdogan's death. The first Action Plan (so headed) appeared at pages 19 to 21 of the Report. The second, headed "Haringey CRHTT (SUI) Action Plan", with pages numbered 1 to 4, appeared immediately after the first Action Plan. It is my understanding that both Action Plans were prepared with a view to ensuring that the recommendations set out in the Report would be implemented.) (1) Although the first Action Plan set out six steps to be taken as "Action in Response to recommendations" and, although the "Date to be completed" for items 1 to 5 was stated to be "November 2014" there was, by the date of the inquest (over two months later) no evidence before me that any of those five steps had been completed. (2) Although the Haringey CRHTT (SUI) Action plan likewise set out nine steps to be taken (some of which corresponded very closely with those set out in the first Action Plan), and likewise set a "Date to be completed" of "November 2014", there was, again, no evidence before me at the inquest that items

	numbers 1, and 3 to 9 had been completed. (3) The risk of further deaths not being prevented will not be diminished if all outstanding steps have not already been completed, and if they are not completed without avoidable delay.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 14 April 2015. 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 Person: [redacted], brother of the deceased (through his solicitors). I have also sent it to [redacted] of Haringey Crisis Resolution and Home Treatment Team, who may find it useful or of interest. 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	**17 February 2015**  ..... **John Taylor** **Assistant Coroner**