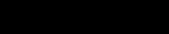



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30 July 2015

Coroner ME Hassell  
Senior Coroner  
Inner North London  
St Pancras Coroner's Court  
Camley Street  
London N1C 4PP

Dear Senior Coroner Hassell


**Re: Mr Mark Patrick Daniels (deceased)**

I write further to your report on the above dated 1 June 2015 in which you highlighted concerns about the care delivered by the Trust to Mr Daniels.

I wish to thank you for bringing your concerns to our attention and I am writing to address the issues you have raised and give assurance that we have taken action to prevent future occurrences.

Following the inquest into the death of Mr Daniels you noted the following failures by the Crisis team:

- a) to visit Mr Daniels twice a day despite a plan to do so;
- b) to record why twice daily visits were not attempted;
- c) to communicate within the team and with the two Crisis houses;
- d) to consider hospital admission despite the fact that Mr Daniels was known to have made several suicide attempts; had told staff he did not feel safe at home; was observed to be keeping a rope at home; told staff he would kill himself, albeit not immediately; said he wanted to be in a contained environment; and there was apparently no prospect of a prompt admission to a Crisis house.

 Associate Divisional Director for the Acute division has considered your concerns and put in place a comprehensive action plan to address them – the action plan is appended at the end of this letter. As you can see from the action plan updates, several

Chair: Leisha Fullick  
Chief Executive: Wendy Wallace

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measures have been put in place across all the Crisis Teams and the Crisis Houses in the Trust to address the concerns you have raised and there is a plan to monitor the implementation of these measures.

I hope you are satisfied that we have taken action to address the concern which you have very helpfully raised.

Yours sincerely,



**Wendy Wallace**  
**Chief Executive**