Regulation 28: Prevention of Future Deaths report

Andrew Elliot FROST (died 25.09.14)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **General Practitioner** **Killick Street Health Centre** **75 Killick Street** **London N1 9RH**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
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 30 September 2014, I commenced an investigation into the death of Andrew Elliot Frost, aged 34 years. The investigation concluded at the end of the inquest yesterday. I made a determination that Andrew Frost took his own life.
4	**CIRCUMSTANCES OF THE DEATH** Mr Frost jumped in front of an underground train early in the morning on 25 September 2014. The day before his death, he had three separate encounters with the authorities, the first with police; the second with police, paramedics, general practitioner and crisis team; the third with police and paramedics.

	On each occasion, concern was shown for Mr Frost and attempts were made to assist him.
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. During the second encounter on 24 September 2014, whilst police and paramedics were at Mr Frost's home, you and he spoke on the telephone. You were worried about Mr Frost and made an immediate referral to the Islington Crisis Team at Highgate Mental Health Centre. You were told that the team did not have sufficient resources to go out to see Mr Frost that afternoon, but that someone would ring him. However, there was no shared understanding between you and the crisis team about what the crisis team could and could not do. You thought that the crisis team's telephone call would include a conversation sufficiently detailed to allow the crisis team to decide whether to conduct a mental health act assessment that afternoon, whereas the crisis team simply intended to arrange an appointment for the following day. You regarded the crisis team as an emergency service, which the team leader told me in court is not the case. It seems that you, your partners, and other general practitioners who refer patients to crisis teams, would benefit from a very specific piece of training and education from the crisis teams about their service, including its limitations. I did not hear evidence that led me to conclude that different action by healthcare professionals on 24 September would have changed the outcome for Mr Frost, but it might for someone else.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 11 May 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 following. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales • Care Quality Commission for England • Professor Dame Sally Davies, Chief Medical Officer for England • [redacted], Mr Frost's partner 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 12.02.15