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:** 1. Barnet Enfield and Haringey Mental health trust Block B2, St. Anns Hospital, Saint Ann's Road, London N15 3TH 2, Department of Health Richmond House 79 Whitehall 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 12th April 2012 I opened an inquest touching the death of Ronald Gittens , 31 years old. The inquest concluded on the 22nd September 2014. The conclusion of the inquest was "Narrative ", the medical case of death was 1a Cerebral Hypoxia 1b Hanging
4	**CIRCUMSTANCES OF THE DEATH** On the 5th April 2012 Mr Gittens was brought by ambulance to St Thomas' hospital when a passer by telephoned for an ambulance having seen and spoken to Mr Gittens in the street. A doctor at St Thomas' assessed Mr Gittens and Mr Gittens agreed to an informal admission and was placed on one-to-one observation. Had no bed been available at Chase Farm Hospital where Mr Gittens was to be transferred Mr Gittens would have been admitted to St Thomas' Mr Gittens was transferred to Chase Farm Hospital where he was assessed again and the plan was for an informal admission. Mr Gittens was left to wait for a bed and intermittently monitored. Staff at Chase

	Farm Hospital did not know that Mr Gittens had been on one-to-one observation prior to his transfer. Mr Gittens left the hospital before being admitted. Mr Gittens was found on the 7th April 2012 at his home having hanged himself using a length of rope from the loft hatch handle. The delay in admitting Mr Gittens and the fact that Mr Gittens was not on one-to-one observation whilst waiting to be admitted contributed to Mr Gittens leaving the hospital, and bearing in mind Mr Gittens state of mind, to his death.
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 transfer of acute psychiatric patients when no bed is available and • The use of CRHTT as a filter to prevent patients in need of a bed from having access to a bed.
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 Thursday 7th 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 Chief Coroner and to the following Interested Persons;- Representatives of the family and the Mental Health 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	**12 March 2015**