Regulation 28: Prevention of Future Deaths report

Komang Jack SUSIANTA (died 29.07.15)

	THIS REPORT IS BEING SENT TO: **1. Dr Kevin Cleary** **Medical Director** **East London NHS Foundation Trust** **Trust Headquarters** **9 Alie Street** **London E1 8DE**
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 3 August 2015, one of my assistant coroners, William Dolman, commenced an investigation into the death of Jack Susianta, aged 17 years. The investigation concluded at the end of the inquest on 29 April 2016. At inquest, the jury made a determination that death arose as a result of a drug related accident.
4	**CIRCUMSTANCES OF THE DEATH** Jack was a 17 year old boy who suffered a drug related psychotic episode after having taken cannabis and ecstasy at a music festival. He was detained by police under s136 of the Mental Health Act and taken to Homerton University Hospital at around 3am on Tuesday, 28 July 2015.

	Following assessment, he was diagnosed as having suffered a substance related psychosis, and was discharged soon after 7am with a plan for follow up. However, after discharge Jack's condition deteriorated. His family recognised this, but did not know how best to help him, other than to stay close and offer love & support. The following afternoon, Wednesday, 29 July, his family called police again but, during the call, he left the family home by jumping through a window. Police attended and he was deemed a high risk missing person. During a line search, police officers saw him running towards a river. One gave chase and nearly caught him, but Jack dodged and then jumped in the river. He submerged and drowned.
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 consultant psychiatrist who assessed Jack on the morning of Tuesday, 28 July, fully expected him to continue to improve. Whilst she was concerned that he might take drugs again, she thought that he had recovered from this psychotic episode. However, she did not communicate to his family: - first and foremost, the fact that she expected him now to be free from all psychotic symptoms; - second, that any recurrence of these symptoms would be a cause for significant concern and potentially immediate action; - thirdly, in exactly what circumstances professional help should be sought on an urgent basis and how to go about this. Jack's family were very worried indeed about his condition. However, because they had not been given the clinical expectation, they did not know that they could/should take him back to hospital, even though he had been discharged only hours before. By the time they rang police that afternoon, Jack was on the point of leaving the house. However, they had felt something was wrong from the evening before. His brother had even trawled the internet looking for appropriate advice.

	I am aware that new systems have been put in place by the East London Foundation Trust at Homerton University Hospital. The one point that I would like most especially to bring to your attention is the need to communicate clinical expectations (preceding return advice) to patients and their families before discharge.
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 July 2016. 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 • Homerton University Hospital NHS Trust • Hackney Child Death Overview Panel • The Susianta family 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** 06.05.16