REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Angela McNab, Chief Executive Officer, Camden and Islington NHS Foundation Trust (CANDI) - [redacted]
1	**CORONER** I am R Brittain, Assistant Coroner for Inner London North.
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** Demi Williams died on or around 11 March 2016, aged 22 years, from the consequences of helium inhalation. An inquest into her death was opened on 22 March 2016 and concluded on 16 December 2016. I recorded a narrative conclusion, which is attached.
4	**CIRCUMSTANCES OF THE DEATH** Ms Williams was detained by CANDI under the Mental Health Act in January 2016, following the development of new psychotic symptoms. During the assessment process Ms Williams stated she had purchased helium gas with the intention of using it to kill herself. Her mental health improved and she was eventually discharged home in early March 2016. However, she was still experiencing suicidal thoughts (but no plans to harm herself) and some anxiety about being back at her own residence. At no point was it was it clarified whether the helium she had purchased had been delivered to her flat. Concerns were raised after Ms Williams did not attend a planned appointment and she was found deceased in her flat on 15 March 2016. Her death resulted from inhalation of helium. A delivery note dated 6 January 2016 was found by police officers who investigated her death. CANDI undertook an investigation into Ms Williams' death. This was available to me in draft form at the inquest. The conclusions set out a main learning point regarding making attempts to contact patients' relatives. There was no reference to the lack of specific risk assessment regarding Ms Williams' potential access to helium.
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 may occur unless action is taken. In the

	circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows – (1) The method that Ms Williams later used to take her own life was specifically described to CANDI during the assessment process in January 2016. I am concerned that, although a general risk assessment was undertaken on several occasions, there was no consideration of the specific risk which Ms Williams had previously described. Furthermore, I am concerned that, as it stands, the Trust's own investigation does not reflect this issue and that the potential for further learning from Ms Williams' death could be missed.
6	**ACTION COULD BE TAKEN** In my opinion action could be taken to prevent future deaths and I believe that the addressee, 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 16 February 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 Chief Coroner, Ms Williams' family, the Metropolitan Police Service and the Care Quality Commission. 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	**22 December 2016**  **Assistant Coroner R Brittain**