Regulation 28: Prevention of Future Deaths report

Jamie Neil Elliott (died 18.11.2016)

	THIS REPORT IS BEING SENT TO: **Dr Navina Evans** **Chief Executive and Director for Mental Health** **East London NHS Foundation Trust** **Trust HQ** **The Green** **1 Roger Dowley Court** **London E2 9NJ**
1	**CORONER** I am: Edwin Buckett Assistant Coroner Inner North London Poplar Coroner's Court 127 Poplar High Street London E14 0AE
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 23rd November 2016 I began an investigation into the death of Jamie Neil Elliott who died aged 52 on the 18th November 2016 at his home address at [redacted]. The investigation concluded at the end of the inquest into his death on 21st April 2016 which was conducted by myself. I made a determination at inquest that the deceased died as a result of hanging on the 18th November 2016 with a conclusion of suicide.
4	**CIRCUMSTANCES OF THE DEATH** On the 10th August 2016 Jamie Elliott referred himself to the Trust

	presenting with thoughts of suicide. Between that date and the 18th November 2016, he was seen by the Home Treatment Team on numerous occasions and was assessed by a Consultant Psychiatrist from the Trust on the 20th October 2016 with further contact with that clinician on the 27th October and 10th November 2016. Jamie also called the Trust Crisis Team frequently in the 3 months prior to death. I found that during this 3 month period, Jamie expressed clear, detailed and escalating suicidal ideations such that he was offered voluntary in-patient admission on the 10th, 13th and 15th November, 2016 but he declined this. Consideration was given to compulsorily detaining him however, clinicians from the Trust were fortified by the fact that Jamie appeared to be receiving private therapy, 3 times a week, from a therapist elsewhere and therefore the fact he was taking some medication and receiving this treatment were factors which weighed in the balance against compulsorily detaining him. In fact, no contact was made between clinicians from the Trust and that private therapist to: (i) verify that treatment (ii) ascertain how Jamie was responding to therapy and (iii) identify whether he was also expressing suicidal ideation to that individual. Had such contact been made clinicians from the Trust would have been in a better position to consider whether to compulsorily detain Jamie and the outcome in Jamie's case may have been different. It was also clear that clinicians from the Home Treatment Team assumed that the contact between Jamie and the Consultant Psychiatrist on the 10th November, 2016 was a face to face psychiatric assessment when this had not been the case. His condition had clearly deteriorated by this time and he was not given a psychiatric assessment on the 10th November or after this date.
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. Evidence was given by the Trust that a Serious Incident Review had identified areas of concern but no changes had been implemented and it

	was not clear when any of the suggested changes would actually be made. My concerns are: 1. Mental health clinicians from the Trust should be required to contact external providers of mental health services, if possible, when a patient is receiving treatment elsewhere, particularly when consideration is being given to compulsorily detain that individual. They should not simply take the patient's account at face value. 2. There should be a psychiatric assessment, by a Consultant Psychiatrist in circumstances where there is a referral to the Home Treatment Team where a patient's condition has worsened. Ideally this should be within 48 hours and should be a face to face psychiatric assessment.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 **27th June 2017**. 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 Mark Lucraft Q.C. the Chief Coroner of England and Wales; • The family of Jamie Elliott. 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	**DATE 25.4.2017 SIGNED BY ASSISTANT CORONER EDWIN BUCKETT**