Regulation 28: Prevention of Future Deaths report

Tony Mark DUNNE (died 21.02.19)

	THIS REPORT IS BEING SENT TO: **1. Dr Paul Gilluly** **Chief Medical Officer** **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 25 February 2019, one of my assistant coroners, Edwin Buckett, commenced an investigation into the death of Tony Mark Dunne. The investigation concluded at the end of the inquest yesterday. I made a determination of suicide. The medical cause of death was: 1a multiple traumatic injuries.
4	**CIRCUMSTANCES OF THE DEATH** Tony Dunne had alcohol dependence disorder and also extreme anxiety & mild depression. He jumped from a 7th floor window late on the evening of 20 February 2019.

	He had been seen by a mental health nurse at Homerton University Hospital emergency department earlier that evening, having been found by police beside an 8th floor window intending to jump, but had refused informal admission and was deemed not detainable under a section of the Mental Health Act. He rang the Crisis Line a little over an hour after discharge. He was not asked if he was feeling suicidal and he rang off after 5 minutes.
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. Mr Dunne rang the Crisis Line a little over an hour after he had been discharged from the emergency department. He had been seen at the emergency department because he had been found by police standing by an 8th floor window intending to jump. The Crisis Line call taker read his medical notes and so knew this history, but nevertheless did not ask him if he was now feeling suicidal. If she had asked him and he had said yes, she could have asked him to come in to the hospital again or she could have called an ambulance for him.
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 21 October 2019. 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 QC, the Chief Coroner of England & Wales • Care Quality Commission for England • [redacted] parents of Tony Dunne • [redacted] brother of Tony Dunne 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** 20.08.19 **SIGNED BY SENIOR CORONER** H.M. CORONER INNER NORTH LONDON