Regulation 28: Prevention of Future Deaths report

Benjamin Rajinder O'HARA (died 02.11.20)

	THIS REPORT IS BEING SENT TO: **1.** [redacted] **Chief Executive** **Camden & Islington NHS Foundation Trust (C&I)** **4th Floor, East Wing** **St Pancras Hospital** **4 St Pancras Way** **London NW1 0PE**
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 16 November 2020, I commenced an investigation into the death of Benjamin Rajinder O'Hara, aged 24 years. The investigation concluded at the end of the inquest on 11 March 2021. I made a determination at inquest that Ben O'Hara jumped from the fourth floor balcony of his home shortly after 10am on Monday, 2 November 2020. It is unclear whether he was able to form the necessary intent to take his life or whether he was psychotic. He had emotionally unstable personality disorder and drug induced psychoses. He had presented to mental health services with increasing frequency in the last months of his life, at times floridly psychotic.

	His medical cause of death was: 1a multiple injuries.
4	**CIRCUMSTANCES OF THE DEATH** Ben O'Hara was arrested by police under section 136 of the Mental Health Act, and brought to Highgate Mental Health Centre. He had informed police that voices were telling him to jump off his balcony. He was detained under section 2 between 18 and 25 September 2020. He was then brought in to a hospital emergency department on 29 September in similar circumstances, but was not detained. He rang the crisis team helpline on 29 and 31 September. On 2 October, he was found on an eighth floor apparently about to jump and was detained, but only overnight. His fatal jump took place on 2 November 2020.
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. 1. None of the healthcare professionals who assessed or treated Mr O'Hara in the period leading up to his death asked if he would give permission for his family to be contacted. If she had been told of his deterioration, his mother would have returned from abroad and stayed with him. 2. There was an alert on Mr O'Hara's medical record, saying that admission to hospital was unhelpful to him. However, this had been placed on the record 18 months before his death and had not been reviewed since. If it had been brought up to date, it could have affected the decision not to detain him on 3 October. 3. The review undertaken on 3 October was with a s12 approved doctor and an approved mental health professional, but was not a formal mental health assessment. If the crisis team had been award of this, they might have sought a formal mental health assessment when Mr O'Hara disengaged from their care on 4 October.

	4. Mr O'Hara did not have a care co-ordinator or other member of the community mental health team in overall charge of his care. This person would have been in a position to note his deterioration and the increasing frequency of his contacts with the mental health services in 2020.
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 17 May 2021. 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. • [redacted] Ben O'Hara's mum • HHJ Thomas Teague QC, the Chief Coroner of England & Wales I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**DATE** **SIGNED BY SENIOR CORONER** 17.03.21 *ME Hassell*