Regulation 28: Prevention of Future Deaths report

Demet AKCICEK (died 27.05.22)

	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 4 April 2022, I commenced an investigation into the death of Demet Akcicek, aged 41 years. The investigation concluded at the end of the inquest on 5 September 2022. I made a determination at inquest as follows. Demet Akcicek died as a result of taking an excess of medication that was both prescribed for her, and obtained by her online. She had suffered long term post traumatic stress disorder and depression, and had become dependent upon [redacted]. She did not intend to take her life.

4	**CIRCUMSTANCES OF THE DEATH** Ms Akcicek was found on the morning of 27 May 2022 by her partner, in bed with their 7 year old son. She had died in the night beside her sleeping child.
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. When the duty worker from Islington complex depression, anxiety and trauma (CDAT) service rang Ms Akcicek for a welfare check on 25 November 2021, Ms Akcicek reported feeling "quite bad" and that she wanted to cry. She explained that she had difficulty performing everyday activities such as cooking and taking her child to school. She said that two nights earlier, her son reported that she had woken chanting, "I don't want to die, I don't want to die". The duty worker (a registered mental health nurse) formed the view that Ms Akcicek needed to be seen by the service, but failed to put her name on the board, and so she was not discussed at the multi disciplinary team meeting and no follow up was arranged. In addition, the duty worker accepted in court that her note of the conversation was insufficient. I found the note difficult to understand and the duty worker was not able fully to explain its meaning. The duty worker told me that she will not make such mistakes again. However, I did not hear evidence of what steps, if any, Camden & Islington Trust has taken to avoid such a situation arising in future.
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 7 November 2023. 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], partner of Demet Akcicek • 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** 07.09.22 *ME Hassell*