



Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
29 Wood Street,
Barnet EN5 4BE

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	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none">1. Department of Health and Social Care, 33 Victoria Street, London SW1H 0EU
1	<p>CORONER</p> <p>I am Peter Straker, Assistant coroner, for the coroner area of Northern District of Greater London</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On the 31st August 2022 I opened an investigation touching the death of Callum Wong who was 17 years old when he died. I opened an inquest on the 23rd September 2022. The inquest concluded on the 27th February 2023. The conclusion of the inquest was "Callum Wong killed himself", the medical cause of death was 1a Asphixia, 1b Hanging (suspension) and under paragraph 2 Mental Health Issues and Asthma.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>On the 27th August 2022 Callum Wong was found having hanged himself [REDACTED] [REDACTED] Mr Wong had had suicidal thoughts in the past but having been supported by his family, overcame them. When Mr Wong had suicidal thoughts again, patient confidentiality issues resulted in those from whom he sought help, not informing his family.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>The MATTERS OF CONCERN are as follows. –</p> <ol style="list-style-type: none">1. Consideration for exceptions to patient confidentiality in cases of mental illhealth, where informing third parties of a patient's condition may result in crucial non-medical support.
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by Wednesday the Twenty-Eighth of June 2023 I, the assistant coroner, may extend the period.</p>



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	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	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons;-</p> <ul style="list-style-type: none">- Mental Health TrustThe Family <p>Department of Health</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	3-5-2023