Regulation 28: Prevention of Future Deaths report

Michael Joseph HINDES (died 15.05.23)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Medical Director** **South West London & St George's Mental Health NHS Trust** **Trinity Building** **Springfield University Hospital** **15 Springfield Drive** **London SW17 0YF**
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 17 May 2023, one of my assistant coroners, Edwin Buckett, commenced an investigation into the death of Michael Hindes, aged 26 years. The investigation concluded at the end of the inquest on 17 October 2023. I made a narrative determination, which I attach.
4	**CIRCUMSTANCES OF THE DEATH** Michael Hindes killed himself [redacted]. One week before he died, he called 999 because he felt suicidal. This was late in the evening on Monday, 8 May. Police attended and took him to St George's Hospital, where he underwent a half hour mental health assessment, after which he was discharged in the early hours.

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 Michael was taken to St George's Hospital, he explained that he had been back and forth from the railway station, each [redacted] He was discharged with a plan for follow up by the community mental health team (CMHT). I was told that the local CMHT meets at the beginning of every week, and then there is sometimes a delay before an appointment is made, so it was likely that Michael would have to wait an absolute minimum of a week to be seen. In the meantime, it was not thought necessary to refer him to the crisis team. Michael's family knew nothing of his mental ill health. He declined an invitation by the nurse assessing him to contact them. He did not want to worry them. Despite her awareness of the multiple therapeutic benefits of the input of a patient's loved ones, the assessing nurse did not in any way try to persuade Michael to allow her to do this. The first that Michael's family heard of Michael's mental ill health was when they heard of his death. I am sure that, had they been made aware of it while he was still alive, they would have done everything in their power to support him and to engage with the mental health services. Families very often complain to me at inquest that mental health services have not done enough to try to bring them in to a patient's care. In spite of the frequency of this occurrence, the lesson does not seem to be being learnt. When you respond to this letter, I should be grateful to know not just what you have done to address the issue in your own trust, but also what you have done to raise national awareness.
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 18 December 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. • The Hindes family • The Care Quality Commission for England • 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** 20.10.23 *ME Hassell*