North London
NHS Foundation Trust

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Private and Confidential
Senior Coroner Mary Hassell
Inner North London
St Pancras Coroner's Court
Camley St
London N1C 4PP

16th April 2025

Dear Ms Hassell

Re Inquest touching the death of Duncan Holloway

I am writing further to the inquest for Mr Duncan Holloway which concluded on 16th January 2025 and following which you issued a Prevention of Future Death report to the British Association for Counselling and Psychotherapy (BACP) and North London NHS Foundation Trust (note, not North West London NHS Trust). The inquest found that Mr Holloway died by suicide after [redacted] at around 5am on 18th July 2024. The matters of concern raised in your report in regard to the Trust are as follows:

Mr Holloway was seen and fully assessed by North West London clinicians when he was taken to hospital by police following an episode of self harm on 30 June 2024. Police attendance had been prompted by Mr Holloway's brother, calling from abroad. Mr Holloway's brother was particularly disappointed that it seemed as if Mr Holloway's care was not joined up between the different agencies.

We would like to begin by expressing our deepest sympathies to Mr Holloway's family and loved ones. We are very sorry to hear that Mr Holloway's brother has concerns with regard to the communication that took place between the agencies involved. It is unfortunate that we only learned of this concern at the end of the inquest hearing which meant that there was not an opportunity to explore the nature of this concern in more detail.

Mr Holloway was assessed by the Trust's Mental Health Crisis and Assessment Service (MHCAS) on 30th June 2024 after emergency services, having been alerted by Mr Holloway's brother calling from abroad, attended his property and brought him to A&E. This was the extent of the Trust's involvement in his care. As the assessing clinician explained in evidence, she was concerned about the circumstances leading to Mr Holloway's attendance in the department and the risk he might pose to himself when under the influence of alcohol or substances. However, he was capacitous and very clear that he did not wish to engage

with mental health or alcohol services. He did not meet the criteria for compulsory detention under the Mental Health Act. The clinician did her best to engage him but ultimately Mr Holloway made the choice to decline any ongoing involvement with services.

The Trust entirely recognises the importance of communication between its services and service users' professional and personal support networks to support joined up care and manage risks. Service users are vital partners in their own care. However, with the exception of key support networks (such those offered by a service user's GP or next of kin), and although we enquire, the Trust relies on service users to expressly alert it to the involvement of any other networks. In accordance with our standard process when anyone is brought to A&E and a mental health assessment is carried out, a summary was promptly sent to Mr Holloway's GP.

The Trust was not aware that Mr Holloway had sought the support of a private therapist and was only made aware of this involvement during the inquest hearing. It appears that the therapist's involvement postdates the Trust's assessment of Mr Holloway at A&E. The Trust always seeks to involve all relevant parties in a patient's care. However, this only possible with their consent and, although we enquire, the Trust is reliant on service users making it aware of who the relevant parties are. It is therefore difficult to see what the Trust could have done differently in this case. Notwithstanding this, the Trust will continue to reflect on this incident, which it will share through its various governance forums as part of its commitment to learning and improvement.

I hope that this response provides the necessary assurance. Please contact me if you have any queries.

Yours sincerely

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[redacted]
Chief Medical Officer

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