Regulation 28: Prevention of Future Deaths report

Duncan HOLLOWAY (died 18.07.24)

	THIS REPORT IS BEING SENT TO: **1. Chief Executive Officer** **British Association for Counselling and Psychotherapy (BACP)** **BACP House** **St John's Business Park** **Lutterworth** **Leicestershire LE17 4HB** **2. Chief Executive Officer** **North London NHS Foundation Trust** **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 2 August 2024, I commenced an investigation into the death of Duncan Holloway, aged 36 years. The investigation concluded at the end of the inquest on 16 January 2025. I do apologise for the late provision of this report. I made a determination at inquest of death by suicide.

4	**CIRCUMSTANCES OF THE DEATH** Mr Holloway jumped off a bridge at approximately 5am on Thursday, 18 July 2024 and was killed by the impact with the railway tracks below.
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. *For BCAP:* 1. Mr Holloway's BCAP accredited psychotherapist did not make any notes of her consultations with him, because he had asked her not to. She gave evidence that she is not bound by law or ethics to keep any notes. Is it appropriate that there is no minimum standard of note keeping following psychotherapy consultations? 2. The psychotherapist said that she had never before had a client who was suicidal. She said that this is not taught at university, though she had completed a post graduate course in working with suicidal ideation. Can it be right that suicidality is completely omitted from BCAP accredited psychotherapy training? 3. When Mr Holloway's friend contacted the psychotherapist to say that he was missing, knowing that he had neither attended nor cancelled their last consultation the psychotherapist was very concerned for his safety. She instructed the friend to go round to his home, but it did not occur to her to call the police. The friend did this, but can it be right that contacting the police in such a situation is not taught as part of psychotherapy planning? 4. The psychotherapist explained in court that she was angry that Mr Holloway's friend disclosed to her that Mr Holloway had died, asking the friend: "Do you have any idea how this impacts me and my ability to do my job going forward?" The psychotherapist said that she (the psychotherapist) was in distress and shock.

	In hindsight, the psychotherapist said that she wished she had referred Mr Holloway to a psychotherapist with more experience in suicidality, she said at inquest because she did not want to be in this situation again with this responsibility. Should there be a mechanism of ensuring that a psychotherapist who is unable to deal with suicidality does not practise with clients who may experience this? *For BCAP and North West London NHS Trust:* 5. 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.
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 22 April 2025. 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], brother of Duncan Holloway • [redacted], friend of Duncan Holloway • [redacted], BCAP accredited psychotherapist • [redacted], GP, Prince of Wales Medical Centre • Care Quality Commission for England • NHS England • HHJ Alexia Durran, 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. She may send a copy of this report to any person who she 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** 20.02.25 *ME Hassell*