Regulation 28: Prevention of Future Deaths report

Faiza Hassan AHMED (died 07.11.14)

	THIS REPORT IS BEING SENT TO: **1. Deputy Assistant Commissioner [redacted]** **Metropolitan Police Service** **Room 918** **New Scotland Yard** **Broadway** **London SW1H 0BG** **2. Dr Fionna Moore** **Chief Executive** **London Ambulance Service NHS Trust** **220 Waterloo Road** **London SE1 8SD** **3. The Department for Work and Pensions** **Caxton House** **Tothill Street** **London SW1H 9NA**
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 11 November 2014, I commenced an investigation into the death of Faiza Hassan Ahmed, aged 31 years. The investigation concluded at the end of an eight day inquest earlier today.

	The jury made a narrative determination, which I attach.
4	**CIRCUMSTANCES OF THE DEATH** In brief, Faiza Ahmed killed herself by stepping in front of a train, following contact in the two days leading up to her death with the Metropolitan Police Service, the London Ambulance Service and the Poplar Job Centre. Fuller circumstances are detailed in the narrative attached.
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 encompassed within the jury's determination attached.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that and your organisations 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 21 March 2016. 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. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales • Association of Ambulance Chief Executives (AACE) • National Ambulance Service Medical Directors (NASMeD) • [redacted], Faiza's mum

	I am also under a duty to send the Chief Coroner a copy of your response. 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 20.01.16