Regulation 28: Prevention of Future Deaths report

Tanya Christine PAGE (died 20.05.14)

	THIS REPORT IS BEING SENT TO: **1. Ms Wendy Wallace** **Chief Executive** **Camden & Islington NHS Foundation Trust** **4th Floor, East Wing** **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 27 May 2014, I commenced an investigation into the death of Tanya Christine PAGE. The investigation concluded at the end of the inquest on 29 January 2015. The determination made by the jury at inquest was that, Tanya Page took her own life while suffering from psychotic depression on the background of emotionally unstable personality disorder.
4	**CIRCUMSTANCES OF THE DEATH** Tanya Page hanged herself whilst detained under a section of the Mental Health Act on Opal Ward of Highgate Mental Health Unit.

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. 1. When Ms Page was transferred from Sapphire to Opal Ward, she disclosed that she had tried to hang herself whilst on Sapphire a few days before. Opal Ward staff members were shocked at this but, though they recorded the disclosure in the medical notes, they did not alert any staff member from Sapphire until after Ms Page's death. From the evidence given by the consultant psychiatrist on Opal Ward, there appeared to be a reluctance to draw attention to this information, because of the perception that it carried with it a criticism of the staff on Sapphire. However, it was important that staff on Sapphire were told, both from the point of view of Ms Page herself, and because this was a valuable piece of learning for them that could affect how they cared for other patients. The worry about perceived blame should not have prevented prompt discussion. There were other learning points discussed during the inquest, such as the necessity to search the laundry room as well as bedroom of a patient feared to be at risk of self harm; the potential for wardrobe doors to act as a ligature point and the desirability of sharing that learning nationally; and the training issues around use of alarms, ligatures, general patient safety and resuscitation techniques. However, evidence was given that steps have already been taken by the trust to act upon these and so I do not need to comment on them further.
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 3 April 2015. 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 • Care Quality Commission for England • Professor Dame Sally Davies, Chief Medical Officer for England • [redacted] Tanya Page's parents • [redacted], consultant psychiatrist, Opal Ward 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** 02.02.15