In the South London Coroners Court
Inquest touching the death of Anne Wilson

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: 1. **Sir Bernard Hogan-Howe, QPM. Commissioner of Police of the Metropolis** 2. **Dr Fionna Moore MBE, London Ambulance Service Chief Executive**
1	**CORONER** I am Sonia Hayes, assistant coroner, for the coroner area of South London
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 5th February 2015 the Senior Coroner commenced an investigation into the death of Anne Wilson, aged 59 years. The investigation concluded at the end of the inquest on 9th July 2015. Miss Wilson admitted to some suicidal ideation during her admission to the Priory Hospital. She showed signs of improvement and was discharged with a care package. She failed to attend a scheduled appointment and a welfare call to the police on 2nd February was downgraded. The conclusion of the inquest was Suicide; Miss Wilson was discovered deceased at her flat on 3rd February and the medical cause of death was hanging.
4	**CIRCUMSTANCES OF THE DEATH** 1. Miss Wilson had a 10 year history of depression. In December 2014 she was admitted to the Priory Hospital with some suicidal ideation. She showed signs of improvement and was discharged on 29th January 2015 with a private care package. She had capacity and did not meet the criteria for assessment for detention under the Mental Health Act. 2. Miss Wilson did not attend an out-patient appointment on 30th January 2015 and she was contacted by her Consultant by telephone. Following lengthy discussion about her well-being, a further appointment was made for 2nd February 2015. She did not attend and her Consultant was unsuccessful in her attempts to contact her that day. 3. The Consultant contacted Miss Wilson's G.P that afternoon and raised her concerns. The G.P was also unsuccessful in attempts to contact Miss Wilson by telephone and a home visit. He telephoned the police at 16:29 raising his concerns for Miss Wilson's welfare and requesting forced entry. He gave a mobile telephone number upon which he could be contacted. The G.P was informed that the police would attend Miss Wilson's flat within the hour. 4. The MPS informed the LAS that the welfare request had been downgraded under their new policy and that they would not attend but did not inform the G.P. 5. The MPS did not pass on the G.P's mobile telephone number to the LAS and the LAS experienced difficulty making contact with the G.P via his surgery. 6. The LAS contacted the MPS on 2nd February 2015 requesting the MPS to make

	contact with the G.P. but this was not done. 7. The G.P contacted the police on 101 on the morning of 3rd February 2015 for an update and to arrange any follow-up care if that was necessary. The G.P was informed that the police had not attended Miss Wilson's flat. The G.P escalated his concerns at 08:42 for Miss Wilson's safety via an emergency call to the police. 8. The MPS officers were immediately dispatched and Miss Wilson's was discovered deceased at 09:00 in her flat having hanged herself from the doorframe. 9. There were no reliable features to estimate the time or date of death. The evidence at inquest was that Miss Wilson's mobile telephone was turned off following calls from her doctors who had left voicemails on 2nd February and notes were found in her handwriting dated 2nd February.
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) In 2014 the Metropolitan Police Service (MPS) introduced a new policy for dealing with requests for and attending welfare checks. The precise date of the implementation of the new policy could not be established at inquest. The MPS and the London Ambulance Service (LAS) have joint working arrangements however the changes made concerning the future handling of welfare checks was not shared with the LAS at that time. (2) MPS staff responsible for dealing with requests for welfare checks were not given training in the new policy and the power-point guidance circulated did not contain: (a) A checklist or examples of questions that should be asked to elicit sufficient information about the concern being raised (b) an example of how to manage a request for a welfare check concerning the mental health of an individual (c) how to manage additional information received once a welfare check request had been closed. (d) The importance of updating those involved in the change in actions being taken by the MPS (3) The information provided by Miss Wilson's G.P to the MPS was available in full with those making the decision to downgrade the request for a welfare check: (a) Miss Wilson had suffered a relapse of severe depression (b) had just been discharged from psychiatric hospital (c) the welfare concern was raised by the discharging Consultant Psychiatrist and G.P (d) the G.P had specifically requested forced entry to Miss Wilson's property (4) The MPS call handler informed Miss Wilson's G.P that the police would attend Miss Wilson's flat within the hour however the request for a welfare check was downgraded without informing the G.P of the change in decision or to seek

	further clarification of his concerns. (5) The MPS did not share the G.P's mobile telephone number with the LAS causing delay making further contact with the G.P. (6) It is unclear what version of the MPS Welfare Check policy in currently in force and a final version has not yet been shared with the LAS despite requests to do so. (7) The MPS and LAS have joint working arrangements but have yet to meet to discuss joint working arrangements under the MPS Welfare checks policy.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 15th September 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 Chief Coroner and to the following Interested Persons [redacted]. I have also sent it to the Mayor of London, [redacted] of the Priory Hospital Hayes Grove and [redacted] Park Practice who may find it useful or of interest. I have also sent it to the Mayor of London, who may find it useful or of interest. 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 coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**21st July 2015** **Sonia Hayes**