In the South London Coroner's Court

Inquest touching the death of Ratidzai Sangare

Report to Prevent Future Deaths (*Coroners (Investigations) Regulation 28)*

	THIS REPORT IS BEING SENT TO: [redacted] **Acting Chief Executive, Oxleas NHS Foundation Trust**
1	**CORONER** I am Selena Lynch senior 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. http://www.legislation.gov.uk/uksi/2013/1629/pdfs/uksi_20131629_en.pdf
3	**INVESTIGATION and INQUEST** On 21st April 2015 I commenced an investigation into the death of Ratidzai Kudakwashe SANGARE, 38. The investigation concluded at the end of the inquest on 17th May 2016. The conclusion of the inquest was that Mrs Sangare died from ligature compression of the neck. The jury recorded a narrative conclusion: that Mrs Sangare died between 5.15 and 8.28a.m. on Millbrook Ward. She was found face down with a dressing gown belt around her neck that caused the ligature compression.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Sangare was a detained patient with a diagnosis of acute psychotic disorder (in remission) and personality disorder. On the morning of her planned discharge she was found unresponsive on the floor of her room with a dressing gown belt around her neck. Efforts to resuscitate her and to call for medical assistant were delayed, though it is not possible to determine whether the delay contributed to the cause of death.
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) Healthcare staff were unaware or did not recognise that Mrs Sangare's condition required immediate cardiopulmonary resuscitation, the activation of the alarm, and the summoning of an ambulance (2) Staff did not respond immediately to alarm when it was activated, on the assumption that it was likely to be a behavioural issue or false alarm rather than a medical emergency (3) Access to a telephone was limited to those with a key to the office, which did not include agency staff.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation 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 **14th July 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 Chief Coroner and to the family of the deceased. 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	**DATE 18th May 2016** **SIGNED BY CORONER** Emma Lynch