Regulation 28: Prevention of Future Deaths report

Siân Louise WITHERIDGE (died 30.05.17)

	THIS REPORT IS BEING SENT TO: **1. Ms Wendy Wallace** **Chief Executive** **Camden & Islington NHS Foundation Trust (C&I)** **4th Floor, East Wing** **St Pancras Hospital** **4 St Pancras Way** **London NW1 0PE** **2. Mr John Gregory** **Chief Executive** **One Housing Group** **Crisis House** **18 Highbury Grove** **London N5 2EA**
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 5 June 2017, I commenced an investigation into the death of Siân Louise Witheridge, aged 36 years. The investigation concluded at the end of the inquest on 10 October 2017. I made a determination at inquest of death by suicide.

4	**CIRCUMSTANCES OF THE DEATH** Ms Witheridge hanged herself at home on 30 May 2017. She had been detained in hospital under a section of the Mental Health Act on several occasions. She then contacted the crisis team on 20 May, attended an emergency unit on 22 May and, at her crisis team assessment on 24 May, reported staring at traffic for hours considering jumping into it. She also told her care co-ordinator that she had a rope to use to hang herself. She was admitted to Highbury Grove Crisis House (operated by OneHousing) on 25 May. She wanted to self discharge on Saturday the 27th but, having spoken to a member of the crisis team at some length, agreed to stay. The plan was for the crisis team to visit each day, for her to have a session with Highbury Grove staff twice a day, and for her risk to self to be reviewed prior to any leave being granted. She saw an advanced practitioner at crisis house on Monday, 29 May. She was planned for crisis team review next on 31 May, but on 30 May she left Crisis House in the morning and was found by police at her home that evening.
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. While Ms Witheridge was staying in Crisis House, her mental health records were not available to the OneHousing staff there. 2. I was told that the written risk assessment provided to Highbury Grove Crisis House was not as detailed as it should have been. I was unable to make a judgement about this myself because no member of the treating teams or those advising them brought the records to court. (This is especially disappointing given that it is a specific instruction contained within every witness summons that was signed and returned.)

	3. The crisis team staff (as opposed to the crisis house staff) did have access to Ms Witheridge's mental health records, but they did not read them any further back than the date of her first call to crisis house during that last episode, i.e. 25 May 2017, despite her very extensive past medical history. There seemed a lack of recognition of the importance of the notes, particularly the older notes. This may explain why no member of the team thought to bring the notes to court for the inquest. 4. One of the crisis team nurses made a plan for a risk assessment to be carried out before Ms Witheridge took any leave. However, this was an unenforceable plan, because Highbury Grove is an open facility. If the crisis team nurse had considered this, he might have decided that Ms Witheridge in fact needed an assessment under the Mental Health Act when she sought to self discharge on 27 May. 5. There seemed a lack of understanding by the staff of the difference between a patient answering positively that they have no suicide plan and a patient simply refusing to answer a question about a suicide plan. False reassurance appeared to have been drawn from the latter. No arrangement was made for the crisis team to meet Ms Witheridge on 30 May. 6. The care offered to service users of Highbury Grove Crisis House and the Islington Crisis Team seemed disjointed and not dovetailed between OneHousing and Camden & Islington NHS Trust. For example, the crisis team members who gave evidence did not have any knowledge of the crisis house procedure for risk assessing before allowing leave. I found it difficult to make further assessment of this because of the lack of medical records, and the presentation to me of the serious incident investigation report only the day before inquest.
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 18 December 2017. 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 Mark Lucraft QC, the Chief Coroner of England & Wales • Care Quality Commission for England • [redacted], adult social care, Camden, Islington & Enfield • [redacted], brother of Siân Witheridge 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** 23.10.17