Regulation 28: Prevention of Future Deaths report

Sandra BODROŽIC' (died 29.06.14)

	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 7 July 2014, I commenced an investigation into the death of Sandra Bodrožic', aged 39 years. The investigation concluded at the end of the inquest on 17 November 2014. I made a determination at inquest that Ms Bodrožic' took her own life, whilst suffering a schizoaffective disorder.
4	**CIRCUMSTANCES OF THE DEATH** Sandra Bodrožic' was at home with her mother when she suddenly ran up to the attic, said goodbye and jumped out of the window, landing on the ground three storeys below.

	Ms Bodrožic' had been detained under the Mental Health Act on 22 October 2013 and admitted to St Pancras Hospital. She was discharged on 11 February 2014 then treated in the community until her 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. Ms Bodrožic' agreed on 23 May 2014 to the recommendation of those treating her that she be admitted to hospital on an informal basis. However, no bed was found for her until 30 May, by which time she had changed her mind. There was no exploration of the possibility of purchasing a bed from the private sector when no NHS bed was available. 2. The consultant psychiatrist treating Ms Bodrožic' formed the view on the evening of 18 June 2014 that Ms Bodrožic' should have a Mental Health Act assessment. However, the psychiatrist was going on holiday the following day and so decided to leave this until her return, rather than asking colleagues. 3. The approved mental health professional (AMHP), a social worker, who visited Ms Bodrožic' on Wednesday, 25 June 2014, decided that she needed a Mental Health Act assessment and immediately made the appropriate referral. However, once the referral was made, it took until the following week for this to be arranged, and Ms Bodrožic' had killed herself in the meantime, on Sunday, 29 June. Healthcare professionals explained in court that Mental Health Act assessments are, by their very nature, urgent, yet there seemed to be a general acceptance by the team that they will usually take several days to take place, in this case from a Wednesday until the following Tuesday. The provision for assessment is open ended, with no apparent sense of urgency, and there is no protocol for the timeframe within which this should take place, nor is a time agreed as appropriate with patient or family.

	Ms Bodrožic's family were not told that, realistically, they could only obtain an immediate assessment by attending a hospital emergency unit.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you and 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 26 January 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 • [redacted], brother and sister of Sandra Bodrožic' 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** 24.11.14