Regulation 28: Prevention of Future Deaths report

Janet WILLIAMS (died 08.03.17)

	THIS REPORT IS BEING SENT TO: **1. Dr Kevin Cleary** **Medical Director** **East London NHS Foundation Trust** **Trust Headquarters** **9 Alie Street** **London E1 8DE**
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 13 March 2017 I commenced an investigation into the death of Janet Williams, aged 54 years. The investigation concluded at the end of the inquest on 10 September 2017. I made a determination as follows. Janet Williams' death was the result of suicide. She hanged herself at home whilst suffering late onset paranoid schizophrenia. This had developed a little over a year before her death. During that time, despite very significant efforts by family members, there was a healthcare professional failure properly to monitor and therefore to assess and treat Ms Williams appropriately.
4	**CIRCUMSTANCES OF THE DEATH**

	Ms Williams became ill in early 2016 and was referred to mental health services by her general practitioner. She was admitted to Brick Lane Ward at the Tower Hamlets Centre for Mental Health on 9 March 2016 as a voluntary patient and discharged to the home treatment team on 8 April. She was under the care of the home treatment team until 29 April, and then again from 16 September until 11 October 2016.
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 Williams' care plan approach (CPA) was not recorded on the computer system and so there were no automatic alerts generated when she was not seen for review at the appropriate times. The lack of computer record of her CPA was never noted. 2. Ms Williams told her care co-ordinator that she was no longer hearing voices, but her daughter raised concerns that this was not true. Ms Williams' care co-ordinator did not at any point in April 2016 or afterwards raise this with Ms Williams, but instead accepted Ms Williams' narrative as accurate. 3. Ms Williams was not reviewed in accordance with the protocol for a person on a CPA. A medical review with her consultant psychiatrist scheduled for 12 May 2016 was cancelled by her care co-ordinator. The reason given was that the psychiatrist was unwell, though in fact she was not. 4. A meeting was then scheduled three months' away, for 9 August 2016, despite the need for medical review and the lack of any alternative arrangement in the meantime. 5. Between 11 October 2016 when Ms Williams was discharged by the home treatment team, to 21 February 2017 when she saw her general practitioner and her care co-ordinator together, Ms Williams' care co-ordinator did not meet with her. 6. Between 11 October 2016 when Ms Williams was discharged by the home treatment team, and her death on 8 March 2017, Ms Williams' care co-ordinator did not arrange for a medical review by the psychiatrist.

	7. When Ms Williams' family attempted to raise concerns with her care co-ordinator, at times their calls were not returned and at other times their concerns were simply not acted upon. She had recently been diagnosed with a very serious mental health condition, but she was not monitored with sufficient care or in some instances at all, and she was therefore not assessed or treated appropriately. 8. Finally, as I know you are aware, the care co-ordinator made several retrospective entries in the medical records that she did not record as being made retrospectively. These entries were made up to eleven months after events, and were made after Ms Williams' death and mostly after my request for a statement from the care co-ordinator in preparation for the inquest. I attach to this report a copy of the report I made to you on 26 July 2017 concerning the death of Songul Bozdag. You will see that there are themes common to both deaths.
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 6 November 2017. I, the coroner, may extend the period. As I have indicated, I wrote to you about similar matters on 26 July 2017 in respect of the death of Songul Bozdag on 9 February 2017. Given the parallels, I hereby extend the period for your response to my earlier letter from 26 September 2017 to 6 November 2017, so you may send both responses at the same time. Your responses 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 • The Health & Care Professions Council • [redacted], consultant psychiatrist • [redacted], care co-ordinator • [redacted], London Borough of Tower Hamlets • [redacted], sister of Janet Williams 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** 11.09.17