Regulation 28: Prevention of Future Deaths report

Noleen Mary McPHARLANE (died 22.04.14)

	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 24 April 2014, one of my assistant coroners, Richard Ian Brittain, commenced an investigation into the death of Noleen Mary McPharlane, aged 41 years. The investigation concluded at the end of the inquest on 6 August 2014. The determination I made at inquest was that Noleen McPharlane died from the ingestion of an excess of a drug she had purchased on the internet. Her intentions in this are unclear.
4	**CIRCUMSTANCES OF THE DEATH** Ms McPharlane had had a lot of contact with the mental health services over the course of her adult life. She had diagnoses of unstable personality disorder, depression and obsessive compulsive disorder.

	In February 2013, her care was taken over by the personality disorder community team at Highgate Mental Health Centre and remained thus until her death a little over a year later.
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 McPharlane had a long history of overdoses and self inflicted wounds, her last admission to hospital for treatment for the consequent physical injuries being in May 2013. However, in the year following that until her death, the clinical specialist who looked after never once asked her directly if she had thoughts of taking her life. 2. The medical records made clear that Ms McPharlane had a history of buying illicit amitriptyline from the internet and taking this to excess. However, in the last year of her life, her clinical specialist never once asked her if this was ongoing, or advised her about this, or explored the issue with her in any way. He now regards this as unacceptable. 3. The clinical specialist, [redacted], by profession a mental health nurse, saw Noleen McPharlane once a fortnight. The sessions were scheduled to last 50 minutes, but frequently only lasted 20 or 30 minutes. He told me that this was because she did not initiate conversation and responded to questions only briefly. He did not feel he had a good rapport with her. No other health professional from Highgate Hospital saw her. [redacted] did speak to his manager, another clinical specialist (by profession a social worker) about Ms McPharlane, and twice over the year to a psychiatrist. However, there was never any exploration of the possible therapeutic benefit of direct input from an alternative healthcare professional. [redacted] now thinks that would have been appropriate.
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 6 October 2014. 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 • [redacted], Noleen McPharlane's mother • Professor Dame Sally Davies, Chief Medical Officer for England 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** 07.08.14