Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
29 Wood Street,
Barnet EN5 4BE

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted] Care UK, 10 Lansdown Stroud, GL5 1BB
1	**CORONER** I am Andrew Walker, senior coroner, for the coroner area of Northern District of Greater 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.
3	**INVESTIGATION and INQUEST** On the 24th April 2013 I opened an inquest toughing the death of Michaela Jade Christoforou , 17 years old. The inquest concluded on the 28th April 2014. The conclusion of the inquest was suicide, the medical case of death was 1a Hypoxic Brain Injury, 1b Hanging and 1c anorexia nervosa and depression .
4	**CIRCUMSTANCES OF THE DEATH** Michaela was 17 years old at the time of her death and a patient at Rhodes Farm Hospital in North London. Michaela was suffering with an eating disorder and a risk of suicide and in the period leading up to her death was not able to leave hospital without the consent of the medical staff looking after her. In January 2013, whilst at home, following an overdose and an attempt at hanging herself, Michaela returned initially to Forest House Adolescent Unit, a bedded unit for young people between the ages of 12 to 18 and then on the 18th January to Rhodes Farm Hospital, a 24 bedded specialist child and adolescent eating disorder service. On the 24th January 2013 Michaela was detained under section 3 of the Mental Health Act 1983 and had to stay in hospital unless her doctors

	allowed her to leave the hospital. On the 14th April 2013 Michaela was in hospital when found with bunting around her neck suspended from a metal locker in a classroom at the hospital. Michaela was taken to St Mary's Hospital Paddington where she died sadly on the 17th April 2013.
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. – That all staff at the unit did not carry with them a ligature cutter.
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 Tuesday 5th November 2013. 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 following Interested Persons;- Members of Michaela's family, Care UK, 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	**25th May 2014**