Regulation 28: Prevention of Future Deaths report

Tamara HOLBOLL (died 09.05.14)

	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 10 May 2014, one of my assistant coroners, William Dolman, commenced an investigation into the death of Tamara Holboll, aged 47 years. The investigation concluded at the end of the inquest on 20 April 2015. I made a narrative determination, which I attach to this letter.
4	**CIRCUMSTANCES OF THE DEATH** Tamara Holboll died from stab wounds to the neck and chest. Her son, [redacted], pleaded guilty to her manslaughter on the ground of diminished responsibility. He has been detained in a secure hospital for an unlimited period.

	Two days before her death, the Holbolls uncharacteristically sought hospital admission from Camden & Islington NHS Trust, because they feared that [redacted] would harm his mother. As you can see from the narrative attached, that admission was never effected.
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. I heard evidence at inquest of a great many changes being implemented by Camden & Islington since Ms Holboll's death, and I have a copy of your 17 point action plan. I shall not rehearse those matters now, but I want simply to re-iterate the overarching point that I discussed with your clinical director of acute services. It seemed to me from the evidence I heard that, when a need for good communication (for example between clinician and bed manager) has been identified, there has been a lack of precision in your trust about exactly what that means and how it needs to be actioned. Rather than simply talking about the need for better communication, it is necessary to identify that information A must be delivered on every occasion, by person B, at time C, and using method D. Without this level of detail, staff are left with a vague concept and the communication is unlikely to achieve the desired result. I appreciate that this does not give you much in the way of specifics to work on, but your organisation has already identified these. What I hope to do is to share with you what I perceive to be a recurring theme in your organisation, that has been particularly highlighted by Ms Holboll's death.
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 June 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 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** 27.04.15