Regulation 28: Prevention of Future Deaths report

Finnulla Catherine MARTIN (died 16.11.14)

	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** **2. Mr Simon Pleydell** **Chief Executive** **The Whittington Hospital NHS Trust** **Magdala Avenue** **London N19 5NF** **3. Detective Chief Superintendent [redacted]** **Islington Borough Commander** **Metropolitan Police Service** **2 Tolpuddle Street** **London N1 0YY**
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 19 November 2014, I commenced an investigation into the death of Finnulla Catherine Martin, aged 35 years. The investigation concluded at the end of the inquest today. I made a narrative determination, which I attach to this letter.
4	**CIRCUMSTANCES OF THE DEATH** Ms Martin took her own life by jumping from the sixth floor balcony of her home, less than an hour after she had been discharged from the Whittington Hospital where she had undergone a mental health assessment.
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. I am conscious that some matters are already being addressed, but I think it would nevertheless be helpful to set out my concerns below. The **MATTERS OF CONCERN** are as follows. **Camden and Islington Trust** 1. It seemed from the evidence I heard that the Camden and Islington Trust psychiatry liaison team (doctor and nurse) operating at Whittington Hospital on the night of 15 November 2015, were not wholly clear about the protocols for receipt of information from police officers bringing patients into hospital on a voluntary basis. 2. The team then saw a patient without waiting to obtain the triage record created by Whittington Hospital Trust staff. 3. The doctor did not ask Ms Martin about thoughts of suicide within the context of her earlier declaration that she would die that night. 4. He did not ask her about any thoughts of harming another person, regardless of the fact he was not aware that she had threatened this. 5. He did not address his mind to what had led up to the police being called for Ms Martin, nor who had called them.

	6. Neither doctor nor nurse obtained a collateral history of events from a family member before concluding their interview with Ms Martin. 7. When they obtained this afterwards and then realised that Ms Martin had left the hospital, they contacted the police but did not characterise this as an emergency. 8. The crisis team did not pass on information received from Ms Martin's sister to the psychiatry liaison team with a sufficient degree of urgency to ensure that this was taken into consideration before the interview with Ms Martin was concluded. **Whittington Hospital Trust** 1. There seemed to be some degree of confusion surrounding the voluntary attendance of a patient with mental health needs accompanied by the police, that suggests a multi agency discussion and agreement would be beneficial. 2. I was told at inquest by Camden & Islington that the Whittington had been unable to locate the Whittington triage record of Ms Martin's attendance, and I did not discover any record of the call made by Ms Martin's sister to the emergency department that night. **Metropolitan Police Service** 1. The police call handler who spoke to Ms Martin did not record that she said: "I need to jump a balcony". This was important information. 2. As I have indicated above, the confusion surrounding voluntary attendance of a patient with mental health needs accompanied by the police, suggests a multi agency discussion and agreement would be beneficial.
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 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 • Professor Dame Sally Davies, Chief Medical Officer for England • [redacted], mother of Finnulla Martin • [redacted] Messrs Kevin & Paul Martin, siblings 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** 29.04.15