Regulation 28: Prevention of Future Deaths report

Emily VOUKELATOU (died 30.06.16)

	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 15 August 2016, I commenced an investigation into the death of Emily Voukelatou, earlier known as Efstratios Voukelatos. The investigation concluded at the end of the inquest yesterday. I made a determination of suicide.
4	**CIRCUMSTANCES OF THE DEATH** Ms Voukelatou left North Camden Crisis House where she was being treated, having first written notes of intent, and travelled to Beachy Head on the afternoon of 30 June 2016, then jumped off the cliff.

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. I heard evidence from the consultant psychiatrist responsible for Ms Voukelatou's care at Crisis House that it is not routine for the crisis team to involve family members in the care of a patient. I wonder whether that is a policy that would benefit from reconsideration? Otherwise potentially helpful input may be lost. One of the mental health nurses said that families are sometimes invited to meetings, but nobody thought about this for Ms Voukelatou. Her family live in Greece, but she was close to her mother and twin sister, and arrangements might have been made, perhaps for a telephone meeting. 2. Ms Voukelatou's sister telephoned Crisis House several times, very worried, both before and after Ms Voukelatou's death (not having been informed that her twin had died), but her calls were never returned. Apparently, these were not passed on to the right people, but witnesses in court were not aware of the detail of this. Leaving relatives' repeated calls unanswered cannot be right. It loses potentially valuable information, creates additional anxiety and is simply discourteous.
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 13 March 2017. 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 Mark Lucraft QC, the Chief Coroner of England & Wales • Care Quality Commission for England • [redacted], consultant psychiatrist • [redacted] twin sister of Emily Voukelatou (on her own behalf and that of their mother) 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** 11.01.16