Regulation 28: Prevention of Future Deaths report

Songul BOZDAG (died 09.02.17)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Medical Director** **East London NHS Foundation Trust** **Trust Headquarters** **9 Alie Street** **London E1 8DE**
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 13 February 2017, one of my assistant coroners, Heather Williams, commenced an investigation into the death of Songul Bozdag, aged 36 years. The investigation concluded at the end of the inquest on 24 July. I made a determination of suicide, when Ms Bozdag, who suffered from schizophrenia, jumped from a tenth floor window of Massey House, Violet Road, London, at approximately 11.20am on 9 February 2017.
4	**CIRCUMSTANCES OF THE DEATH** Ms Bozdag had been under the care of mental health services for approximately twelve years before her death. As well as schizophrenia, she had been diagnosed with recurrent depressive disorder, obsessive compulsive disorder symptoms and psychotic symptoms.

	Her last inpatient admission was on 29 June 2016 to Brick Lane Ward of Tower Hamlets Centre for Mental Health, initially informally but later detained under section 3 of the Mental Health Act. She was discharged from the ward on 23 August 2016, and last seen for review by her psychiatrist and care co-ordinator on 8 February 2017, which was the day before she died.
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 Bozdag's care co-ordinator did not arrange for what was a mandatory seven day review of Ms Bozdag after discharge from hospital in August/September 2016. 2. She recorded monthly reviews of Ms Bozdag on only half of the months from September 2016 to Ms Bozdag's death in February 2017, though monthly reviews were mandatory. 3. The care co-ordinator gave evidence at inquest that she had actually reviewed Ms Bozdag once a fortnight when Ms Bozdag came for her depot injections, but in the main did not record these discussions. She did include in her statement for the court one note recording the nature of a discussion had on 10 February. This was in fact the day after death. She said this was an error. 4. She described having a very good recollection of individual consultations with Ms Bozdag, such as one on 6 September 2016 though there was no record supporting this description. However, she had not had a sufficient recollection of Ms Bozdag's treatment during her life to notice that the need for a care plan approach (CPA) had not been recorded on the computer system. 5. Finally, the care co-ordinator did not ensure that the drug card in use reflected the psychiatrist's increased prescription of 50mg of risperidone rather than the original one of 37.5mg. Ms Bozdag was therefore under medicated on an ongoing basis. These were the errors of an individual, but there is an additional point that they were not captured by any sort of system safety net during Ms Bozdag's life.

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 the report, namely by 26 September 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 • [redacted], consultant psychiatrist • [redacted] care co-ordinator • [redacted], husband of Songul Bozdag • [redacted], niece of Songul Bozdag 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** 26.07.17