REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. John Brouder, Chief Executive, North East London Foundation Trust, Goodmayes Hospital, Barley Lane, Goodmayes, Ilford, Essex, IG3 8XJ**
1	**CORONER** I am Nadia Persaud, Senior Coroner for the Eastern Area 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. http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 24th June 2015 I commenced an investigation into the death of Laura Theresa McRory. The investigation concluded at the end of the inquest on the 6th June 2016. The conclusion of the inquest was a narrative conclusion: *Mrs Laura McRory suffered from severe anxiety and associated alcohol misuse. She was noted to be deteriorating in her mental state and alcohol misuse in the weeks leading up to her death. On 20th June 2015 she was taken to hospital by her sister in the hope of receiving help. After assessment by a registered mental nurse, she was discharged home, without any immediate follow up or continued observation. The following day her husband found her intoxicated and later unresponsive. She died from alcohol and mixed drug consumption. The evidence does not reveal her intention at the time of consuming the fatal mix of drugs and alcohol.*
4	**CIRCUMSTANCES OF THE DEATH** Laura McRory was a 40 year old lady who had a past medical history of recurrent episodes of anxiety and depression, associated with alcohol misuse. She worked for the North East London Foundation Trust (NELFT). In the weeks leading up to her death, she suffered a deterioration in her mental state and increase in alcohol consumption. She was taken to Whipps Cross Hospital A&E on the 20th June 2015. She was assessed by the NELFT psychiatric liaison team (a Registered Mental Nurse). Mrs McRory made it clear that she did not want to be assessed by staff working for the same Trust as her. The RMN in his statement to the Court stated: "A voluntary psychiatric admission was not the direction Mrs McRory wanted to go, not least because it would have meant further assessment by the Home Treatment Team for consideration; the very same service that she worked in, which would have been utterly humiliating" Mrs McRory was discharged from hospital, following the psychiatric team's assessment.

	The following day Mrs McRory was found by her husband to be unresponsive. Paramedics were called, but she could not be resuscitated. Post mortem investigations revealed a cause of death of alcohol and mixed drug consumption. I heard evidence during the course of the inquest from [redacted] He confirmed his opinion that a more robust safety plan should have been in place at the end of the psychiatric consultation on the 20th June 2015. In particular, he considered that there should have been a request for Mrs McRory to be admitted under the medical team for observation. An admission under the medical team may well have been acceptable to Mrs McRory as this was not the Trust for whom she worked. It was clear from the evidence of her sister [redacted] that the A&E staff had considered that Ms McRory required admission. [redacted] also considered that a protocol was required, to deal with the issue of referral out to a neighbouring Trust, where a member of NELFT staff requires mental health care.
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. – • Mrs McRory was employed by the North East London Foundation Trust. She was clearly concerned about providing thorough and detailed information to NELFT staff, concerning her mental state and alcohol misuse. • The evidence revealed a need for a clear process to be in place when NELFT staff require mental health care and express reservations about sharing information with colleagues. • The Trust's investigation report found that there were no care or service delivery problems. The report however did not analyse to any degree the issues relating to the complexities surrounding NELFT employees seeking help for mental health conditions. The report also did not to any extent consider whether there was an adequate safety plan in place on discharge. • [redacted] did not consider there to be an adequate safety plan in place for Mrs McRory. He also considered that there needed to be a system in place for staff to be promptly referred to a different Trust where they present with mental health difficulties and request services from a different Trust. [redacted] did confirm that he was in the process of drafting a protocol to deal with this issue. A copy of the draft protocol was not provided. • In light of the length of time that has elapsed since the date of Mrs McRory's death and the inadequacies of the Trust's internal investigation, I consider it necessary to write a Regulation 28 Report to ensure that the Trust considers the system in place for prompt referrals to be made to another Trust, where necessary, for members of NELFT staff who require mental health care. If a protocol is to be drafted, I would like the Trust to confirm how this will be disseminated to frontline staff.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 **8th August 2016**. 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: [redacted] (Husband), [redacted] (Mother) and [redacted] (Sister). I am also forwarding a copy of the report to the Care Quality Commission and to [redacted], Director of Public Health – who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. I will also disclose your response to the above, interested persons. 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	**[DATE]** 13.6.16 **[SIGNED BY CORONER]**