MISS N PERSAUD
SENIOR CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Ministerial Correspondence and Public Enquiries Unit** **Department of Health and Social Care, 39 Victoria Street. London, SW1H 0EU** Sent via email to: [redacted] And, [redacted]**, CEO, North East London NHS Foundation Trust.** **Trust Head Office, CEME Centre- West Wing, Marsh Way, Rainham, Essex, RM13 8GQ** Sent via email to: [redacted]
1	**CORONER** I am Graeme Irvine, acting senior coroner, for the coroner area of East 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/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 26th November 2019 I commenced an investigation into the death of Steven Paul David Gary Stout age 40. The investigation concluded at the end of the inquest on2nd March 2021. The conclusion of the inquest a narrative conclusion: *"Mr Steven Stout was detained by police on the morning of 14 October 2019 under*

	section 136 of the Mental Health Act 1983. Mr Stout was intoxicated by alcohol and had cut both of his wrists. *Following medical treatment for his injuries Mr Stout was assessed at the section 136 suite at hospital. Following a Mental Health Act assessment, Mr Stout was made subject to an order under section 2 of the Mental Health Act 1983. After a three-day delay Mr Stout was admitted to a mental health ward on 17 October 2019.* *On the ward Mr Stout is assessed by a consultant, it was determined that he ought to be discharged from the section two order with support in the community from the home treatment team.* *Mr Stout was discharged from the ward on 18 October 2019 without a referral to the home treatment team, accordingly he was not supported in the community by them.* *On 4 November 2019 Mr Stout was found unresponsive, suspended by his neck from a ligature. Despite the prompt attendance of emergency services, he could not be resuscitated and his life was pronounced extinct at 07:43 hours. Mr Stout had deliberately taken his own life.* *Although it is possible that home treatment team support in the community could have avoided this outcome, it cannot be said, on the balance of probability, that home treatment team intervention would have probably provided an opportunity to save or preserve Mr Stout's life."* The medical cause of death was: 1a Suspension
4	**CIRCUMSTANCES OF THE DEATH** See above narrative
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 could 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. The failure of Turner Ward, Goodmayes hospital to accurately record and file important medical records including; decisions on discharge, risk assessments, and a crisis, relapse and contingency plan. 2. The failure of Turner Ward Goodmayes hospital to ensure the effective referral of a patient from the ward to the home treatment team within the community.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 28th April 2021** 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 the family of Mr Stout, the CQC. I have also sent it to [redacted] Director of Public Health who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**3rd March 2021** **[SIGNED BY CORONER]**