MISS N PERSAUD
HER MAJESTY'S CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted], CEO, North East London Foundation Trust, West Wing, CEME Centre, Marsh Way, Rainham RM13 8GQ [redacted]
1	**CORONER** I am Nadia Persaud area 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 the 23rd December 2020 I commenced an investigation into the death of David Ayontunde Walker aged 27 years. The investigation concluded at the end of the inquest on 20th October 2021. The conclusion of the inquest was a narrative conclusion: *Mr Walker took his own life on the 27th November 2020. This was, in part, because risk information was not correctly shared between two treating mental health trusts; the risk of David taking his own life was not fully assessed and necessary precautions were not taken on his discharge from hospital on 23rd November 2020.*
4	**CIRCUMSTANCES OF THE DEATH** David Walker suffered from mental and behavioural disorder due to drug use. His mental

	health deteriorated from January 2020. In July 2020, David attended London Bridge with the intention of [redacted]. He was too scared [redacted] and did not take any action at that time. Two days later he attended [redacted]. A member of the public called the emergency services and David was admitted to the Newham Centre for Mental Health (under East London Foundation Trust). David remained an in-patient until 11 August 2020. Very shortly after his discharge from hospital, David attended a [redacted]. He was taken back to the Newham Centre for Mental Health where he was admitted for a further short period. During July and August 2020, David was also under the care of the community recovery team of North East London Foundation Trust. He had a care co-ordinator allocated to him by North East London Foundation Trust. This information about the care co-ordinator was available to East London Foundation Trust, but there was no contact with the North East London Foundation Trust care co-ordinator. The North East London Foundation Trust care co-ordinator did not elicit the risk information from David and did not make enquiries of East London Foundation Trust. On the 9 November 2020, David travelled to [redacted]. He was admitted to a local hospital under section 2 of the Mental Health Act, and was transferred under section to Goodmayes Hospital (North East London Foundation Trust). David's mental health improved during the course of the admission. The in-patient team did not seek collateral information from East London Foundation Trust and were unaware of the incidents in July and August 2020. The discharge risk assessment was therefore, incomplete. Had the Consultant been aware of the prior incidents, she would have considered a longer inpatient admission; considered granting leave under the supervision of the home treatment team or discharge under the care of the home treatment team. Instead, David was discharged to the community recovery team. There was one telephone discussion with David on the 25 November 2020, by the team at Goodmayes Hospital. On the 27 November 2020, David's mental health appeared to deteriorate after a return to work interview. David was found [redacted] during the evening of 27 November 2020. His life was pronounced extinct on scene. Police attended and deemed the circumstances as non-suspicious.
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. Between end of May 2020 to November 2020, Mr Walker was allocated four different care co-ordinators. There was evidence that only one of these care co-ordinators established a therapeutic relationship with Mr Walker. Many of the care co-ordinators were locum staff. 2. On admission to hospital on the 10th November 2020 no steps were taken to seek collateral information from other Trusts involved in the care of Mr Walker. Mr Walker had been under the care of East London Foundation Trust in July and August 2020 and this Trust held a great deal of vital risk information that should have been available to the North East London Foundation Trust team. There was no evidence that the admission check list included the requirement for collateral healthcare information to be sought.
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 by **15th December 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 Walker, the CQC and the local Director for Public Health. 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	**21st October 2021**