MR G IRVINE
ACTING SENIOR CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: 14653252

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Ministerial Correspondence and Public Enquiries Unit Department of Health and Social Care, 39 Victoria Street. London, SW1H 0EU Sent via email to:** [redacted] 2. [redacted]**, Chief Executive, ELFT, East London Foundation NHS Trust, 9 Alie St, London E1 8DE Sent via email:** [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 23rd July 2021 I commenced an investigation into the death of Mr Ian Cockfield, a man aged 53 years old. I opened an inquest on the 28th July 2021, the inquest was heard, before me on 24th May 2022. The conclusion arrived at was a narrative conclusion;

	"Mr Ian Michael Cockfield died in hospital on 12th July 2021. *At the time of his death he was receiving involuntary inpatient treatment for mental health issues. During that admission he underwent medical investigations that resulted in a preliminary diagnosis of metastatic liver and abdominal cancer.* *On the evening of the 12th July 2021 Mr Cockfield collapsed requiring emergency paramedic treatment. Mr Cockfield was taken by ambulance to the major trauma centre where he subsequently sustained a cardiac arrest, despite* *resuscitative efforts he was declared dead that evening at 22.06."* The medical cause of death was found to be; 1a Carcinomatosis
4	**CIRCUMSTANCES OF THE DEATH** See narrative conclusion above
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. On Sunday 11th July 2021, Mr Cockfield was discharged from hospital after treatment. The patient was discharged to a mental health ward at a different hospital. Upon arrival at the mental health ward at 16.00hrs, a review of the patient's falls risk assessment was not undertaken. The following day, Mr Cockfield suffered a fall whilst mobilising, unsupervised by staff. Mr Cockfield sustained a serious laceration to his head.
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 **21st July 2022**. 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 Cockfield, the Care Quality Commission and the Nursing & Midwifery Council. 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	**[DATE] 25th May 2022 [SIGNED BY CORONER]**