MISS N PERSAUD
HER MAJESTY'S CORONER
EAST LONDON
East London Coroners Court, Adult Learning College, 127 Ripple Road, Barking, IG11 7PB
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: 14169257

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], North East London NHS Foundation Trust. Trust Head Office, CEME Centre- West Wing, Marsh Way, Rainham, Essex, RM13 8GQ **Sent via email to:** [redacted] 2. [redacted], Assistant Director of Integrated Commissioning, London Borough of Waltham Forest, NHS North East London Clinical Commissioning Group, TNW Integrated Care Partnership and North East London Health and Care Partnership, 4th Floor, Unex Tower, 7 Station Street, London, E15 1DA **Sent via email to:** [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 24th June 2021 I commenced an investigation into the death of Louise Asha Allen, aged 41 years old. The investigation concluded at the end of the inquest on the 5th July 2022. The conclusion of the inquest was a narrative conclusion: *Louise Allen took her own life whilst suffering from a mental health disorder. She was*

	recognised as a very high risk to self, but in the months leading up to her death she did not receive the care that was necessary to protect her from the high risk with which she presented.
4	**CIRCUMSTANCES OF THE DEATH** Louise Allen suffered from bipolar disorder and emotionally unstable personality disorder. She was discharged from hospital following a lengthy admission to hospital in mid-December 2020. She was regarded as a very high risk to self and she required a careful and comprehensive community care-plan. Between February 2021 to June 2021 she did not receive the necessary mental state assessments by her care-co-ordinator; there was no additional support provided to engage her in activities to assist in promoting her recovery. In addition, inaccurate clinical details were on occasion presented to the multi-disciplinary team, resulting in unreliable risk assessments. On the evening of the 12th June 2021 Louise travelled to [redacted] where she placed herself in front of a train.
5	**<u>CORONER'S CONCERNS</u>** 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: Louise Allen did not receive a care plan that was adequate to address the high-risk of harm to herself. This was largely due to failings in the co-ordination of her care. The Inquest heard that care co-ordinators are fundamental to the safe provision of care for high-risk service users. Concerns heard during the evidence at the inquest include: 1. There is a need within the Trust for better continuity of care. There are not enough care co-ordinators to ensure that continuity of care is provided. There are high turnovers of staff. 2. Efforts need to be made to make the post of care co-ordinator more attractive. The evidence heard that the pay within North East London Foundation Trust is not comparable to other Trusts. 3. Care Co-ordinators within the Trust are currently carrying excessive caseloads. 4. There has been an increase in the number of referrals coming into the service. There has been no commensurate increase in the number of care co-ordinators. 5. Whilst the Trust has over recruited in terms of the financial budgets, it is still under recruited in terms of the clinical need for care co-ordinators.
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 **12 September 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 Louise Allen, the Care Quality Commission and to the local 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	**12/07/2022 [SIGNED BY CORONER]**