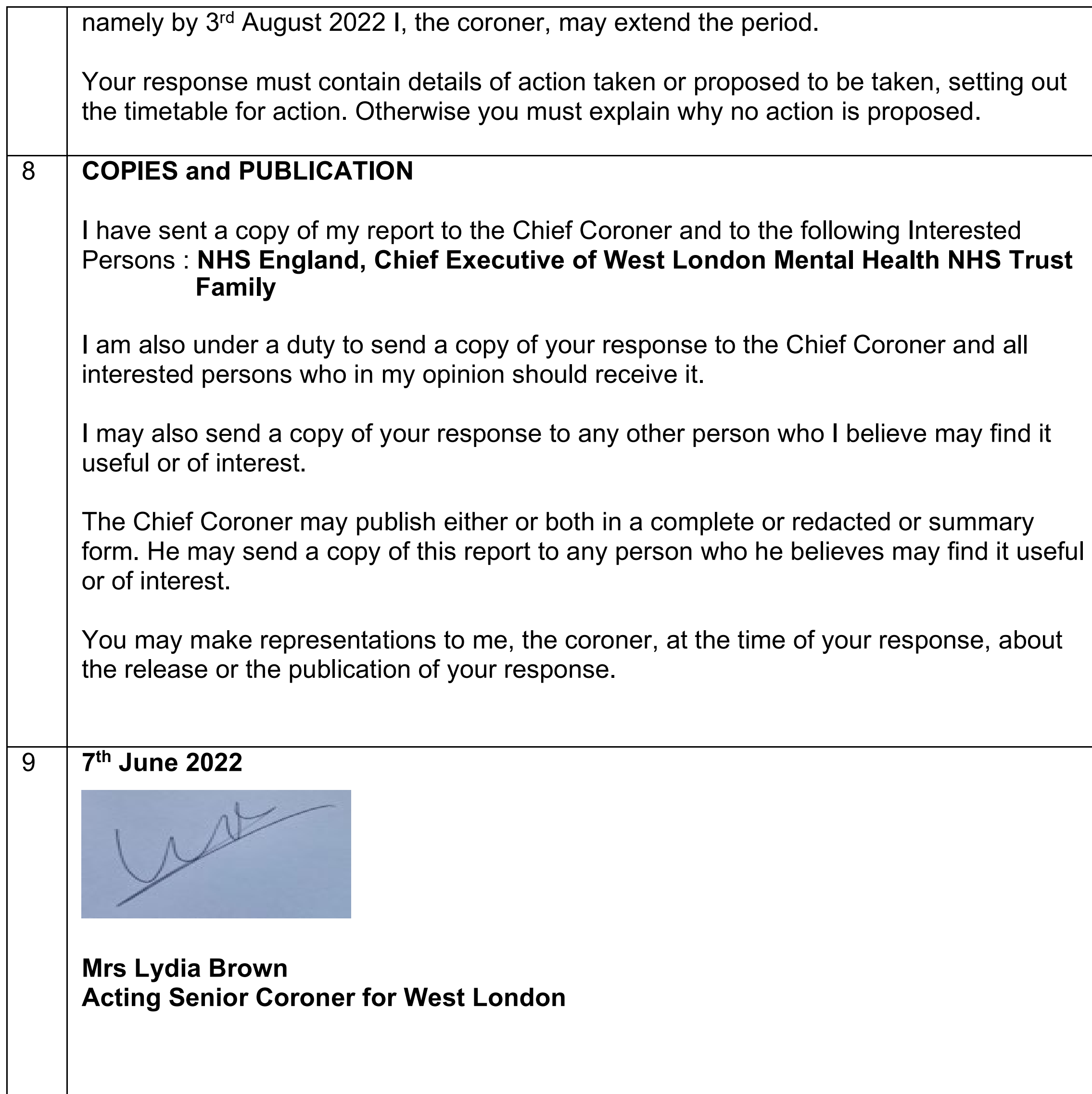
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. NHS England** **2. Chief Executive of West London Mental Health NHS Trust** **3. Family** **4. Chief Coroner**
1	**CORONER** I am Lydia Brown, Acting senior coroner, for the coroner area of West 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.
3	**INVESTIGATION and INQUEST** On 10 October 2021 I commenced an investigation into the death of Mena Tekloe Marim Teferi, aged 49. The investigation concluded on 19 May 2022. The conclusion of the inquest was death due to suicide, the medical cause of death being 1a Suspension
4	**CIRCUMSTANCES OF THE DEATH** Mena took her own life using a ligature and was found deceased at home, [redacted] on 10 October 2021. She was under the care of the North Ealing Mental Health integrated network team but this team was critically under-resourced and unable to cope with the level of referrals to their service. She was not seen when she should have been on referral from the emergency department on 23 September, was not discussed in the daily zoning meeting as she should have been and was then lost to follow up the following week and not seen or contacted before her death. It is not possible to say if this could have changed the outcome.
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. – The mental health services went through a transformation process during the Covid pandemic. It became apparent that the anticipated level of direct referrals to the service from primary care was many times in excess of those predicted. The expectation was 6 per day, at the peak this rose to 30 and has currently reduced to 13-14 daily, so remains over 100% above the anticipated level. The inquest was advised that the service was failing to meet the service demands due to insufficient capacity. The decision was made to enter this onto the Trust's risk register, and this remains the situation. The critical features remain a high demand for services and a lack of resources. This court has been told on many occasions that there is an intention for "parity" of mental

	health services with physical health services, but this is not apparent and the service is unable to meet its obligations now or going forward. This is greater than a “long waiting list” issue and is not a situation that can be explained exclusively by the covid pandemic. A more significant risk to individuals requiring mental health services has now arisen than existed before the transformation programme; it creates a real concern that lives will be lost as a consequence, and no solution was offered to the court during the inquest. The service is set up to deal with less than half of the referrals that it receives, leading to inevitable failings that currently cannot be rectified.
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 3rd August 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 : **NHS England, Chief Executive of West London Mental Health NHS Trust** **Family** 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	**7th June 2022** [signature] **Mrs Lydia Brown** **Acting Senior Coroner for West London**