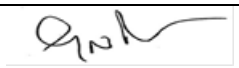
MISS N PERSAUD
HIS MAJESTY'S CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: 15428988

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted]**NHS England** [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 13 October 2021 I commenced an investigation into the death of Ms Aleksandra Markowska age 41 years. The investigation concluded at the end of the inquest on 27 September 2022. The conclusion of the inquest was a narrative conclusion: *Alexandra took her own life whilst suffering from pregnancy related depression and anxiety. She had suffered from severe symptoms for around four months. Despite seeking help from a number of sources she did not receive a review by a perinatal psychiatrist.*
4	**CIRCUMSTANCES OF THE DEATH** Between 17 June 2021 to the 21 July 2021 Alexandra had multiple contacts with the

	British Pregnancy Advisory Service (BPAS). She presented to the service with distress, agitation, anxiety and conflict over her pregnancy. On the 10 July 2021 a treatment unit manager identified a concern in relation to Alexandra's mental health and her mental capacity. The treatment unit manager considered that Alexandra required a mental health assessment. There was no direct access to a perinatal psychiatrist, so a safeguarding referral was made. The outcome of the referral is unknown. Alexandra did not undergo any review by a perinatal psychiatrist and she did not have a full capacity assessment undertaken. She expressed conflicting views about her pregnancy up until the termination of pregnancy took place on the 17 July 2021. On the 1 July 2021 Alexandra presented to her GP with anxiety, depression and insomnia relating to her pregnancy. She was referred to the mental health services and a review by a psychiatrist was requested. Alexandra did not receive an assessment by a psychiatrist. Within the mental health trust, Alexandra received contact from multiple teams but did not receive a full mental health assessment or a full assessment of her risk to self. There was an absence of joined up working and an absence of psychiatric attention. On the 30 September 2021 Alexandra was found unresponsive at the bottom of 21 Gardner Close, E11. Resuscitation was attempted by the emergency services, but sadly her life was pronounced extinct on scene. The evidence indicates that she had jumped [redacted] Police found no evidence of third party involvement. There were no substances found on toxicology that would have impaired Alexandra's ability to form an intention to take her own life. A note had been sent indicating her intention to take her own life.
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 British Pregnancy Advisory Service (BPAS) is a charity whose services are often commissioned by the NHS. As a charity, BPAS does not have direct access to NHS perinatal psychiatrists. Referrals would have to be made either via the patient's GP or via an unwieldy safeguarding concern (as happened in this case). Referrals via the GP are not possible where the patient does not wish their identity to be revealed. It is a matter of concern that there is no direct access for BPAS patients who are suffering from pregnancy related mental health decline, to peri-natal psychiatry teams. Direct and confidential access to peri-natal psychiatry teams may reduce the risk of future deaths.
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 **23rd November 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 Ms Markowska, to the other interested persons to the Inquest, the CQC 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	**29 September 2022**  G N Persaud