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: 109860

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted], Chief Executive Officer, East London Foundation Trust [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 14th February 2019 I commenced an investigation into the death of Mrs Donna Michelle Neill, age 45 years. The investigation concluded at the end of the inquest on 13th September 2022. The conclusion of the inquest a narrative conclusion: *Donna Neill died as a result of a fatal ingestion of oxycodone and pregabalin. She was living in hazardous conditions and was unable to keep herself safe. Failings on behalf of her familial carer, her mental health team and her social care team contributed to her death. There was a failure to fully assess and manage a clear risk of Donna ingesting medication that was not prescribed to her. Her death was contributed to by neglect.*
4	**CIRCUMSTANCES OF THE DEATH** Donna Neill suffered from emotionally unstable personality disorder, mental and

	behavioural disorder due to drug use and mild learning disabilities. She was not capable of living independently and was not capable of managing her own medication. She required the involvement of mental health and social care services. In July 2018 concerns arose in relation to her living environment and by November 2018 concerns arose about the suitability of her husband, as her carer. Safeguarding procedures should have been instigated in July 2018. In August 2018, a closure order was put in place to keep drugs users out of her home address. The order was breached on several occasions and by November 2018, consideration was being given to also excluding her husband from her home. A meeting took place on the 4 December 2018 with Donna, her husband, the mental health team and her social worker. It was clear at this meeting that Donna was not receiving her required medication. In addition, it was disclosed that Donna was taking her husband's medication. The risk of harm to Donna from taking her husband's medication was not fully assessed and was not appropriately managed. On the 10 December 2018, Donna was found deceased in her bed in her home address. She died as a result of an overdose of medications prescribed to her husband. This was a risk that was clearly foreseeable and was a risk that she should have been protected from.
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. – A clear risk was raised at the CPA meeting on the 4th December 2018. This was the risk of Donna taking medications prescribed to her husband. This risk was not documented in the Trust's mental health records, not fully assessed and no risk management plan was put in place to protect Donna from harm. The absence of a risk assessment and management plan was not identified as a failing within the Trust's internal investigation report and no steps have been taken by the Trust to improve the systems in place.
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 **22nd 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, family of Donna Neill (via her solicitors), Newham Safeguarding Adults, I have also sent it 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	**[DATE] 28 September 2022 [SIGNED BY CORONER]**