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: 13486020

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • [redacted] Acting Chief Executive Officer, North 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 the 5th May 2021 I commenced an investigation into the death of Mary Ebere Nwanonyiri, aged 33 years. The investigation concluded at the end of the jury inquest on 25th November 2022. The conclusion of the inquest was a narrative conclusion: *Mary died following a cardiac arrest that occurred on the 19th April 2021. Her health declined whilst a resident in the care of Goodmayes Hospital. Had there been evidence of physical observations, this may have prevented her sudden decline. The absence of a care plan contributed to her death.*

4	**CIRCUMSTANCES OF THE DEATH** Mary Nwanonyiri was admitted to Goodmayes Hospital following a deterioration in her mental state on the 9th April 2021. She was an inpatient at the hospital until she was found unresponsive in her room on the 19th April 2021. During the course of the admission, Mary had largely declined medication and vital signs observations. During the course of the 10-day admission to hospital, under section 3 of the Mental Health Act, there was no written care plan for Mary. There was no completed risk assessment document with an associated risk management plan. Mary was found unresponsive in her bedroom on the morning of the 19th April 2021. Post-mortem investigations revealed that she died as a result of Covid-19 infection. The expert witness was unable to fully explain the apparent rapid decline in Mary's physical condition.
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. Senior nursing staff who gave evidence at the Inquest did not appear to appreciate the importance of an agreed comprehensive care plan in which the multi-disciplinary ward team, patient and relatives are involved. The nursing staff did not acknowledge the value of a holistic care plan which incorporates the consideration of the many ways in which patients can be supported to engage in their recovery. Such a care plan could also incorporate assessments of capacity to refuse physical observations. There was no clear evidence of assessment of Mary's capacity to refuse physical observations. 2. A number of nurses failed to recognise the acute clinical severity of Mary's condition on the morning of the 19th April 2021. They did not respond to her very concerning clinical state with the necessary urgency.
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 **26 January 2023** 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 Mary Nwanonyiri, the Care Quality Commission. 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	**1 December 2022 [SIGNED BY CORONER]**