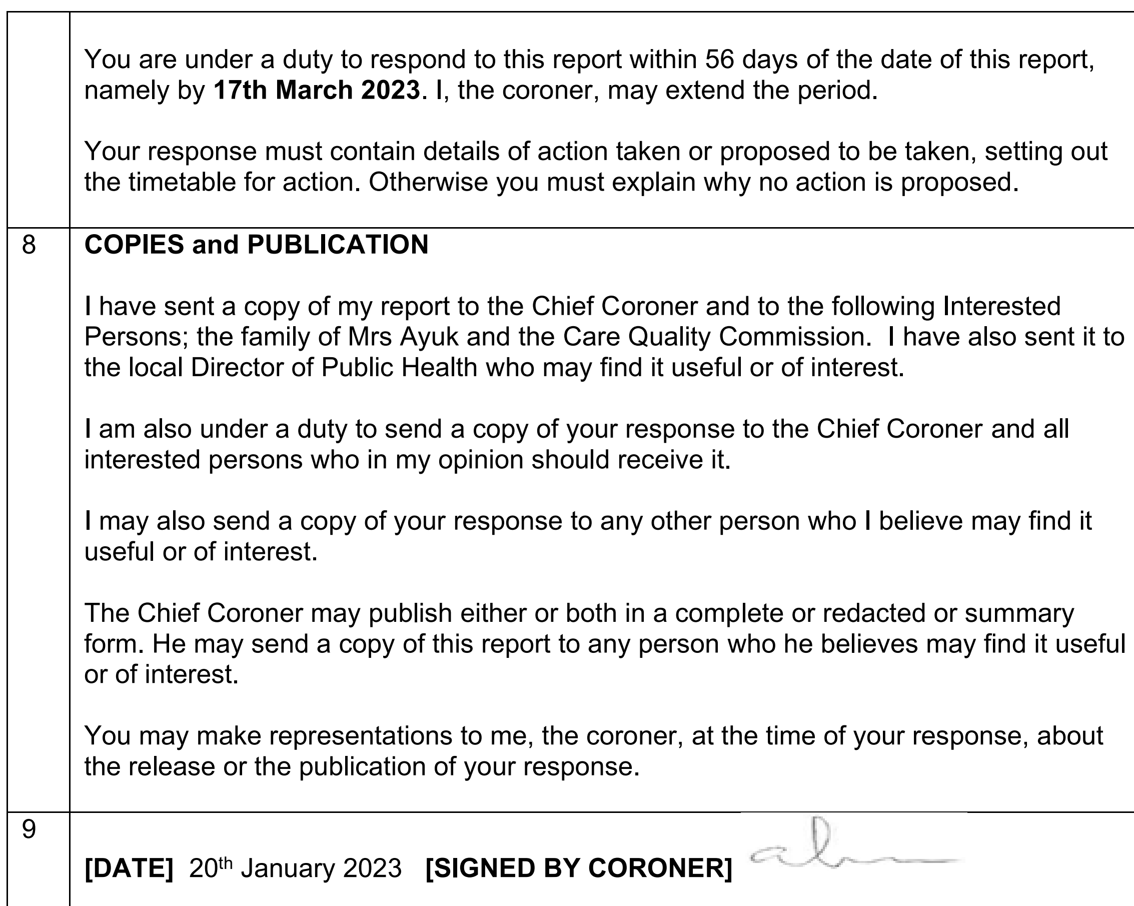
MR G IRVINE
SENIOR CORONER
EAST LONDON
East London Coroners Court, Adult Learning College, 127 Ripple Road, Barking, IG11 7PB

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Chief Executive Officer, East London Foundation Trust, 9 Alie Street, Goodmayes, Ilford, IG3 8XJ 2. RT Honorable Therese Coffey, Secretary of State for Health & Social Care, 39 Victoria Street, Westminster, London, SW1H 0EU
1	**CORONER** I am Graeme Irvine, senior 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 19th March 2022 I commenced an investigation into the death of Sophia Ayuk age 34 years. The investigation concluded at the end of an Article Two compliant inquest held on 18th and 19th January 2023. I arrived at a narrative conclusion. *"Sophia Abunaw Ayuk died in hospital on 18th March 2023 as the result of a pulmonary embolism. A deep vein thrombosis had developed in her left calf due to Sophia sitting motionless in her room on the day of her death.* *Sophia's behaviour on 18th March 2022 was due to her mental illness.* *Ms Ayuk had not taken any food or drink for at least two days prior to her death.*

	Dehydration may have contributed to the development of Ms Ayuk's thrombosis." The medical cause of death was determined following a post-mortem examination; *1a Pulmonary embolus* *1b Deep vein thrombosis* *II Schizophrenia (treated)*
4	**CIRCUMSTANCES OF THE DEATH** Ms Ayuk had been diagnosed with Hebephrenic Schizophrenia since 2013, her illness was treatment resistant and consequently, was treated with Clozapine. Ms Ayuk had been treated in the community and in hospital to manage her symptoms. In October 2021 Ms Ayuk suffered a relapse of psychosis and was admitted under S.2 of the Mental Health Act to a mental health ward for treatment. After a period of stabilisation Mrs Ayuk was discharged home but returned shortly thereafter when symptoms returned in January 2022. At the time of her death Ms Ayuk had yet to be successfully titrated back on to Clozapine and consequently, was experiencing symptoms of her illness On 18th March 2022 Ms Ayuk was observed by staff to remain in her bedroom all day. Sophia sat, fully clothed and motionless on a chair for most of the day. Sophia would not respond to verbal prompts and declined food and drink. At 20.45.49 Ms Ayuk was seen to emerge from her bedroom and walk down a corridor to the main area of the ward. Moments later Sophia fell to the floor and a patient alerted staff. Staff made an emergency call for the rapid response team and went to Sophia' assistance. Ms Ayuk was breathing and conscious at that time. Sophia began to deteriorate and 999 was called at 21.04. Paramedics responded promptly and on arrival found Sophia unresponsive but breathing. No pulse could be found and CPR was commenced. Resuscitation continued for 90 minutes until Sophia was declared deceased.
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. – 1. At no time during the two periods of Ms Ayuk's inpatient care was she assessed for venous thromboembolism (VTE) risk in contravention of trust policy. 2. Instructions given to monitor and record Ms Ayuk's food and fluid intake were not adequately followed.
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 **17th March 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 Mrs Ayuk and 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	**[DATE]** 20th January 2023 **[SIGNED BY CORONER]**