MISS N PERSAUD
HIS MAJESTY'S CORONER
EAST LONDON CORONERS COURT
124 Queens Road, Walthamstow E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • [redacted], 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 19th May 2022 I commenced an investigation into the death of Carol Ann Robinson age 70 years. The investigation concluded at the end of the inquest on 22nd March 2023. The conclusion of the inquest a narrative conclusion: *"Mrs Robinson died as a result of an overdose of medication. The evidence does not reveal her intention at the time of taking the overdose."*
4	**CIRCUMSTANCES OF THE DEATH** On the 7 May 2022, Carol Robinson called a family member to report that she had taken an overdose of medication (quantity and identity of medication unknown). The family member called the emergency services and ambulance service personnel attended. The

	first response paramedic tried to elicit the history, but was unable to determine from Mrs Robinson what medication had been taken. There was a delay in conveying Mrs Robinson to hospital, in the order of around 50 minutes, but there is no evidence that this delay contributed to her death. Mrs Robinson was taken to Queen's Hospital where a diagnosis of mixed drug toxicity, on the background of severe co-morbidities, was made. She was provided with intensive care. Sadly she did not recover and she passed away at Queen's Hospital on the 8 May 2022. By way of background, Mrs Robinson had taken an overdose in March 2022 and had received care from the mental health home treatment team. On the 25 April 2022 she was discharged back to the care of the general practitioner. She was not assessed by a doctor in the home treatment team before her discharge and she did not receive a comprehensive risk assessment in the days leading up to her discharge. Whilst such assessments and reviews should have taken place, it is not possible to conclude that they would have prevented her death. It is noted that there were no documented concerns about her mental health between the 26 April and the 6 May 2022.
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. Mrs Robinson did not receive a medical review by a doctor within the Home Treatment Team prior to her discharge back to the care of her GP on the 25th April 2022. 2. Mrs Robinson did not receive a comprehensive risk assessment prior to her discharge from the Home Treatment Team on the 25th April 2022. 3. There was no multi-disciplinary team discussion to ensure a safe community plan following discharge from the Home Treatment Team. There was no communication with regard to the withdrawal of the Home Treatment Team's input, with the domiciliary care agency or family of Mrs Robinson.
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 **25 May 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 Carol Robinson, 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	**30 March 2023**