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] 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 20th June 2022 I commenced an investigation into the death of Evelina Vilkiene aged 45 years. The investigation concluded at the end of the inquest on 2nd March 2023. The conclusion of the inquest a narrative conclusion: *Evelina Vilkiene took her own life whilst under the care of the mental health services. She was at increased risk of harm to herself following a decision to wean her clonazepam medication on the 26 May 2022, but there was no careful risk management plan and there were no significant assessments of her mental health following the 27 May 2022".*
4	**CIRCUMSTANCES OF THE DEATH**

	Evelina Vilkiene suffered from a first psychotic episode in November 2021 and required care from the mental health services. She was admitted to the care of the intensive home treatment team and then transferred to the care of the early intervention in psychosis team. In April 2022 she presented in crisis again, presenting with severe depression. She was accepted again by the home treatment team and remained under their intensive support until 21 May 2022. There was no detailed risk assessment at the time of step-down, or jointly agreed risk management plan. At the time of step-down she presented as anxious in relation to her medication and showed a dependence to clonazepam. A medical plan was set to wean her off the clonazepam on the 26 May 2022, with no carefully devised risk management plan put in place. There was no care co-ordinator visit following the medical review on the 26 May 2022. On the 7 June 2022, Evelina was found hanging in the basement of her home address. A paramedic pronounced her life extinct on scene. Police deemed the circumstances as non-suspicious. A note was found which contains Evelina's stated 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: 1. When Evelina was stepped down from the Home Treatment Team to the Early Intervention Psychosis Team, there was no detailed risk assessment or jointly agreed risk management plan. 2. On the 26th May 2022 when a decision was made to wean Evelina from the Clonazepam medication there was no detailed risk assessment or risk management plan. It was agreed in evidence that there was an increased risk to self at this time. No additional steps were put in place to ensure insofar as possible, that Evelina was kept safe. 3. Following the medical review on the 26th May 2022 there were no further care co-ordinator reviews. This was in contravention of the general requirement for amber zoned patients to be seen at least weekly.
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 **30 April 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 Evelina Vilkiene, 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	**6th March 2023**