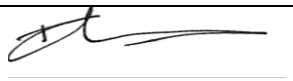
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Medicines and Healthcare products Regulatory Agency (MHRA)**
1	**CORONER** I am Mrs Priya Malhotra, assistant coroner, for the coroner area of Inner West 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.
3	**INVESTIGATION and INQUEST** On 2 November 2021 an investigation commenced into the death of Federica Cavenati, aged 28 years. The investigation concluded at the end of the inquest on 9 October 2023. The conclusion of the inquest was that Federica Cavenati did the act of jumping [redacted], London with the intention of taking her own life, which was more than minimally contributed to by service delivery issues, including that she had not taken consistent antidepressant medication for some time since her admission due to her physical condition, arising from an act of self-harm; drinking oven cleaner. The medical cause of death was 1a multiple traumatic injuries and 1b fall from height.
4	**CIRCUMSTANCES OF THE DEATH** On 12 September 2021 Federica Cavenati [redacted] cause herself harm. She was admitted to the Chelsea and Westminster Hospital where she was treated for her physical and mental health on a medical ward. She had previously been prescribed anti-depressant medication, however due to her physical health and the unavailability of anti-depressant medication intravenously, she did not receive this medication until she was physically able to, which was shortly before her death. Her 1:1 mental health nursing observation was removed on 17 September 2021. Her last review by the Psychiatry Liaison Team was on 17 October 2021 with no further review taking place. On 15 October 2021 she refused her blood line. On 16 October 2021 she refused her medication (including Ensure supplement) and again on 17 October 2021. On 18 October 2021 she was found [redacted]. She sustained multiple traumatic injuries resulting her in death on 18 October 2021. The following factors contributed more than minimally to her death: 1. She had not had a recent mental health review. 2. There were no mental health observations. 3. She had not taken consistent anti-depressant medication for some time.
5	**<u>CORONER'S CONCERNS</u>** During 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. – The absence of intravenous anti-depressant medication for those in need, who cannot for physical reasons take the medication orally. The evidence I heard confirmed the

	existence of intravenous anti-depressants in Europe but not in the United Kingdom.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 20 December 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: Federica Cavenati's family, the Chelsea and Westminster Hospital and the Central and North-West London NHS Foundation Trust who operated the Psychiatry Liaison Team. I have also sent it to the National Institute for Health and Care Excellence (NICE) who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. 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 by the Chief Coroner.
9	 **25 October 2023**