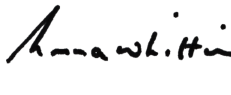
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Interim Chief Executive ELFT -** [redacted]
1	**CORONER** I am Emma WHITTING, Senior Coroner for the coroner area of Bedfordshire and Luton Coroner Service
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 12 September 2022 I commenced an investigation into the death of Angela Dawn COLLINS aged 50. The investigation concluded at the end of the inquest on 30 November 2023. The Conclusion of the Inquest was a **Narrative Conclusion**: ***"The Deceased died from an overdose of prescription drugs taken whilst she was suffering from severe mental and emotional distress".***
4	***CIRCUMSTANCES OF THE DEATH*** The Inquest found that: *The Deceased had a history of depression which was made significantly worse by the death of one of her children in 2012. After taking a prescription drug overdose in February 2022, she came under the care of the Community Mental Health Team. After taking a further intentional prescription drug overdose on 3 May 2022, she was provided with a period of in-patient psychiatric treatment. Although she was discharged back to the Community Mental Health Team following her discharge, she did not attend her appointment with the Community Psychiatrist on 14 July 2022. By early August 2022, although it was clear that her mental health had deteriorated and that her relationship with her Community Mental Health Team Key Worker had broken down, she was not seen by any clinically qualified staff and had limited mental health support. A crisis point was reached when she awoke in the early hours of 18 August 2022 in distress and, after packing a bag which included half a week's medication, left her home at 04.00 hours. Police subsequently attended her home and found a note suggesting a possible intention to harm herself. She was deemed to be a high-risk missing person and, after an effective search by police, she was located at the Travelodge in Toddington; although she denied being suicidal, police made further referrals to the Mental Health Team and Social/Children Services with concerns for her welfare. Although requested by Social/Children Services to see her, the Community Health Team did not go to see her but, instead, attempted to contact her by telephone. When the Deceased called them back at around 16.09 hours, her call was answered by administrative staff and, when she could not be put through to the clinically trained Duty Officer, she terminated the call. Although the Duty Officer called her back shortly after, she did not answer and no further action was taken. At around midnight, Travelodge staff found the Deceased slumped in the hallway outside her room. On informing them that she had depression, Covid 19, and had taken an overdose* [redacted]*, they called an ambulance. Owing to service demand, there was a 3 hour wait for an ambulance and, when the paramedics arrived at 03.43, they*

	found her in cardiac arrest on the bed in her room. Despite all resuscitation efforts, her death was confirmed at 04.29 hours. A bag containing multiple packs of medication [redacted] *was found under the bed and post-mortem examination confirmed that she had a blood level of* [redacted] *within the fatal range as well as an excess of* [redacted]*. A note found at the scene included the words "if I should die.."*
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: *Vulnerable adults at risk of accidental/intentional prescription drug overdose and potentially suffering a mental health crisis (such as Angie) appear to receive very limited or no support even though they are under the care of secondary mental health services provided by East London NHS Foundation Trust.*
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 January 29, 2024. 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 **Team Manger of Children Services, Central Bedfordshire Council –** [redacted] [redacted] **– Next of Kin** I have also sent it to **DDC of Bedfordshire Police –** [redacted] 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 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 by the Chief Coroner.

9	**Dated: 04/12/2023**  **Emma WHITTING** **Senior Coroner for** **Bedfordshire and Luton Coroner Service**