**MISS N PERSAUD**
**HIS MAJESTY'S CORONER**
**EAST LONDON**
**Coroner's Court, 124 Queens Road Walthamstow, E17 8QP**
[redacted]

**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

Ref: [redacted]

| | |
|---|---|
| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>1. [redacted], **CEO, North East London Foundation Trust (NELFT), CEME Centre, March Way, Rainham, Essex, RM13 8GQ Email: Email:** [redacted] |
| 1. | **CORONER**<br><br>I am Nadia Persaud area coroner for the coroner area of East London |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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.<br>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7<br>http://www.legislation.gov.uk/uksi/2013/1629/part/7/made |
| 3 | **INVESTIGATION and INQUEST**<br><br>On the 19 March 2024 I commenced an investigation into the death of Dean Martin Ford (aged 40). The investigation concluded at the end of the inquest on the 2 December 2024. The conclusion was that Mr Ford died as a result of suicide. |
| 4 | **CIRCUMSTANCES OF THE DEATH** |

| | |
|---|---|
| | Mr. Ford suffered a decline in his mental health on the 1 March 2024. He was suffering from intrusive thoughts relating to past trauma. His partner was concerned about his mental health and contacted the secondary care crisis team in the very early hours of the 2 March 2024. Mr. Ford spoke with the crisis contact. The crisis team did not take a full history or carry out a full risk formulation. Mr. Ford was informed that he would be referred to the community mental health team. The referral was made, but on the 4 March 2024 the referral for secondary care mental health services was declined. The reasons for declining the referral were not set out in the records or in the letter to the general practitioner. No further information was sought from Mr. Ford or from his partner before declining the referral. There was no formulation of risk in accordance with the relevant NICE guidelines (issued in September 2022), before declining access to secondary mental health services. It is not possible to determine, on the balance of probabilities, what decisions would have been made by the community mental health team, had a full risk formulation been carried out on 4 March 2024. It is therefore not possible to state on the balance of probabilities that a full risk formulation on 4 March 2024 would have prevented Mr Ford's death on 10 March 2024. On the 6 March 2024, Mr. Ford had a telephone consultation with his GP. He explained that he had experienced suicidal thoughts on the 1 March 2024, but stated that he would not act on these thoughts. He described clear protective factors. The GP prescribed anti-depressants and a review appointment was set for the 20 March 2024. Crisis information was also provided by the GP. On the evening of the 9 March 2024, Mr. Ford had a disagreement with his partner. At around 0850 on the 10 March 2024 he left home. At 1035 he is seen on CCTV buying a length of rope. At 1350 he was found hanging in Bedfords Park, Romford. Emergency services were called and paramedics pronounced his life extinct on scene. Police attended and deemed the circumstances as non-suspicious. There were no substances found on toxicology which would have prevented Mr. Ford from forming an intention to take his own life. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) Despite clear guidance from NICE in September 2022 relating to the need for a holistic formulation of risk to self, two NELFT teams involved in Mr Ford's crisis care failed to carry out a holistic formulation of the risk he posed to himself.<br>(2) A clinical lead for the mental health and wellbeing team within NELFT, gave evidence at the inquest in December 2024 that Mr Ford's risk was deemed to be low because "the main factor around risk is that he denied any risk to self and denied any suicidal thoughts". This simplistic assessment of risk is not compliant with the NICE guidelines. It is of concern that a senior member - clinical lead - within the mental health and wellbeing team is not applying the correct risk formulation.<br>(3) The Trust carries out risk assessment audits for clients who are accepted into the mental health and wellbeing team. There are no audits into the risk assessments for those persons who are referred to the team, but not accepted by the team. As these patients have no safety net of ongoing mental healthcare, it is of concern that the quality of risk assessments for these |

| | |
|---|---|
| | patients is not audited. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 30 January 2025. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the family and partner of Mr Ford. The report has also been sent to the Care Quality Commission and to the local Director of Public Health who may find it useful or of interest.<br><br>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.<br><br>I may also send a copy of your response to any other person who I believe may find it useful or of interest.<br><br>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.<br><br>You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response. |
| 9 | **4 December 2024**  |