MISS N PERSAUD
HIS MAJESTY'S CORONER
EAST LONDON
East London Coroners Court, 124 Queens Road, Walthamstow, London E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], CEO, North East London Foundation Trust (NELFT), CEME Centre, March Way, Rainham, Essex, RM13 8GQ **Sent via email:** [redacted] Cc: [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 27 November 2024 I commenced an investigation into the death of George Kenneth Fraser, aged 37 years old. The investigation concluded at the end of the inquest on the 14 May 2025. The conclusion of the inquest was an open inquest, as the cause of Mr Fraser's death was unascertained.

4	**CIRCUMSTANCES OF THE DEATH** Mr. Fraser was a 37-year-old gentleman who had suffered from schizophrenia, hypothyroidism and misuse of alcohol. He required admission to a mental health hospital under a section of the Mental Health Act from 20 February 2024 to 18 March 2024. On discharge, he received very regular input from the Home Treatment Team until 9 May 2024, when he was transferred to the Mental Health & Wellbeing Team. There was no clear care plan in place whilst he was under the care of the Mental Health & Wellbeing Team. A new Care Co-Ordinator was allocated on the 5 June 2024. This Care Co-Ordinator met with Mr. Fraser on only one occasion (19 June 2024). Mr Fraser did not converse with the care co-ordinator at this time, so a meaningful risk assessment could not be completed. The last recorded contact with Mr. Fraser by the NHS services was an administrative call on the 9 July 2024. Family last had contact with him on the 8 July 2024. Visits were made by the mental health and wellbeing team on 16 July 2024, 22 July 2024 and the 24 July 2024 but there was no response. The family were informed that Mr. Fraser was "denying entry". The team did not make it clear to the family that they had received no response at all from Mr. Fraser - either to home visits or telephone calls. The mental health team did not notify the family that a friend had also raised concerns about a lack of contact with Mr Fraser on the 18 July 2024. When a further failed visit occurred on the 29 July 2024, the mental health and wellbeing team requested that the family assist them in gaining access to Mr. Fraser. Mr. Fraser's sister attended his home address and found him clearly deceased within the premises. A paramedic attended and pronounced his life extinct on scene. Police attended and deemed the circumstances as non-suspicious. A post-mortem examination was carried out. Despite a post-mortem examination, which included specialist tests for toxicology and neuropathology, a cause of death could not be identified. The pathologist considered that Mr. Fraser had likely passed away a few weeks before he was found. There was a lack of clear risk assessment, risk management and care planning by the Mental Health and Wellbeing Team, but it is not possible to reach a conclusion about the causal effect of this, as both the date when Mr Fraser passed away and the cause of death are unascertained.
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) There was no clear and documented care plan in place whilst Mr Fraser was under the care of the Mental Health and Wellness Team. There was a lack of structure to the care provided to Mr Fraser by the Mental Health and Wellness Team. (2) There was no robust risk assessment carried out by the Mental Health and Wellness team. (3) The Mental Health and Wellness Team had been unable to reach Mr Fraser from the 16 July 2024. On the 18 July 2024 a friend contacted the mental health team to raise concern about his lack of contact with Mr Fraser. No action was taken at this time to review the risk of harm to Mr Fraser or to determine whether the Trust's missing person procedure should be activated. There was no meaningful contact with the family to report the concerning lack

	of contact with Mr Fraser, until the 29 July 2024.
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 **22 July 2025**. 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 Mr George Fraser, the Care Quality Commission and 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	**23 May 2025**