



West London Coroner Service
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Date: 30 June 2025
Case: 35521132

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: CGL (Ealing RISE) CORONER

1 I am **Lydia Brown Senior Coroner** for **West London**
CORONER'S LEGAL POWERS

2 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>

INVESTIGATION and INQUEST

On 21 June 2024 I commenced an investigation into the death of Ella Colette La-India DAVID-FONG. The investigation concluded at the end of the inquest. The conclusion of the inquest was

3 Drug related death

1a Metonitazene and alprazolam intoxication

1b

1c

II

CIRCUMSTANCES OF THE DEATH

4 Ella was found collapsed on the street outside her home and resuscitation was attempted, but she died in Ealing Hospital later the same day on 17 June 2024. She had taken a number of illicit drugs that resulted in an unintentional drug overdose. She had a long history of illicit drug use and although she was engaging with services she was unable to abstain or achieve recovery.

CORONER'S CONCERNS

5 During the course of the inquest the evidence revealed matters giving rise to concern. In my

opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. -

Ella had a very supportive and engaged family, but at times she withdrew consent from the agencies trying to provide care and support and refused for information to be shared with her family. As a capacious adult she was entirely able to make this decision, and the agencies had to respect this. The important information the family had was not therefore shared to assist with and improve Ella's care. Confidentiality and consent are key concepts in establishing the trust necessary to build effective therapeutic relationships as well as required under the legal framework.

(1) It was acknowledged at inquest that there is currently inadequate information provided for family and carers regarding this challenging issue. The court was advised that it would be appropriate to provide further information at the commencement of treatment both by leaflets provided to the family and carers and on the website to set out the legal position of consent and confidentiality, together with information to assist family and carers in how they can share concerns and communicate information when consent is withdrawn. Currently there is no effective information of how communications can be received, without breaching the confidentiality requirements and this was stated to be a learning point for Ealing RISE at the inquest hearing.

ACTION SHOULD BE TAKEN

- 6 In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

YOUR RESPONSE

- 7 You are under a duty to respond to this report within 56 days of the date of this report, namely by 1st September 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons

- family

- West London NHS Trust

8

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 30 June 2025

Signature

A handwritten signature in black ink, appearing to be 'Lydia Brown', written over a horizontal line.

Lydia Brown Senior Coroner for West London