

Office of the Chief Medical Officer
Trust Headquarters
Robert Dolan House
5th Floor
9 Alie Street
London E1 8DE

Private & Confidential



Date 30 April 2026

Dear Madam,

RE: RESPONSE TO REGULATION 28

1. I am writing to provide a response to the concerns that you raised after the conclusion of the inquest touching the death of Ms Caroline Adeyelu.
2. The Trust gratefully notes your observations, and wishes to update you on its work in the following areas:
 - **Concern 1** - *“The evidence at the inquest reflected very poor appreciation of the risks posed to Mrs Adeyelu by her mentally unwell adult son. This poor appreciation of risk was observed at all levels of clinical staff. Whilst I note that the safeguarding training within the trusts includes reference to the adult child to parent domestic abuse, I am concerned that the extent of training on this subject is insufficient to address the widespread concerns encountered in this case. In relation to the risk of domestic abuse in this case there was a lack of information gathering from wider family members; there was a lack of carer support; a lack of homebased risk-assessment; a lack of home visits by the clinical team; an absence of safeguarding referrals for Mrs Adeyelu and an absence of multi-agency risk assessment/risk management. It has been brought to my attention that the Femicide Census (2000) found that for women killed by immediate family members, over 80% were mothers killed by their sons. Mental health of the perpetrator was a context of the violence in 58% of those cases. In light of this, and in light of the evidence heard at the inquest, I am concerned that the risk of adult child to parent domestic abuse is a matter that requires more substantive consideration in safeguarding training, than is currently provided.”*



- **Concern 2** - *“The inquest heard concerns from multiple witnesses about the lack of effective communication systems in place between the mental health services and the Metropolitan Police Service, in circumstances where there are dual forensic and mental health concerns. Whilst there are clearly higher-level meetings that take place between the trusts and the MPS, these do not address the needs of psychiatrists and police officers working on the frontline who are having to address pressing risk issues - both in assessing and in managing risk. Such liaison needs to be prompt - in some cases immediate. Liaison may be from the MPS to the Trust (for example in risk assessing missing persons) or from the trust to the police (for both risk assessment and how to best manage risk). The inquest heard that communication both ways was challenging. The challenges have increased since the introduction of the Right Care, Right Person policy has been introduced. In some cases, communication was not attempted at all, because of the assumption that the appropriate professional was unlikely to be reached. Both trusts and the MPS are asked to consider a process for direct and immediate operational liaison between the police and NHS mental health staff for individuals presenting with a risk of violence compounded by mental ill health.”*
3. The Trust has undertaken a great deal of reflection and learning since Ms Adeyelu’s very sad death on 30 October 2022. I outline this work below to provide you and Ms Adeyelu’s family with reassurance that the Trust has taken this matter very seriously.

Concern 1: The extent of training at the Trust on this subject is insufficient to address the widespread concerns encountered in this matter.

4. Through-out the inquest process, the Trust provided you with evidence as to the training and systems it has put into place to prevent intergenerational domestic abuse. This included:
- The Trust’s level three safeguarding training now highlights domestic abuse from children (with or without mental health needs) to parents.
 - The learning identified from the Trust’s Individual Management Review (IMR) provided for the Domestic Homicide Review into Ms Adeyelu’s death was considered in Tower Hamlets quarterly safeguarding supervision on 4 July 2024 and 5 June 2025.



- Domestic abuse and Violence Against Women and Girls (VAWG) Champions have been trained across all clinical service areas in Tower Hamlets to support clinicians.
 - An intergenerational domestic abuse training session was held virtually at the Trust's annual safeguarding conference (delivered by the charity Hourglass).
 - Tower Hamlet's admissions checklist was updated on 23 December 2025 to include intergenerational safeguarding concerns.
 - The Trust strengthened its guidance and approach to routine enquiry into domestic abuse.
5. Upon receiving your Regulation 28 report, the Trust further strengthened its Level 3 Safeguarding Training (which is mandatory for all patient facing clinical staff). It now explicitly references evidence from the Femicide Census and the Domestic Homicides and Suspected Victim Suicides 2020-2025 Report ([published April 2026](#)) on the prevalence of mothers being killed by their sons and the frequent presence of mental ill health as an antecedent risk factor in the section on children-adult abuse.
6. The training is designed to challenge mental health professional's perceptions that family is always inherently protective and reinforces parental vulnerability when caring for adult children with mental health support needs. The training highlights that caring roles should not be assumed but actively explored and verified. It places emphasis on ensuring that mental health professionals explicitly consider risk to family members as well as partners and ex-partners and assess whether these risks meet the threshold for domestic abuse. It also stresses that risks should not be viewed solely through a mental health lens: abuse must be recognised as abuse, regardless of whether mental ill health is present, and should be responded to through appropriate safeguarding and domestic abuse pathways.

Concern 2 - Processes for direct and immediate operational liaison between the police and NHS mental health staff for individuals presenting with a risk of violence compounded by mental ill health.

7. The Trust also provided evidence at the inquest as to the improved processes that have been put into place between the police and the Trust since Ms. Adeyelu's death. This included:



- Training of all staff in Tower Hamlets in relation to expectations about contacting the police after Right Care, Right Person commenced.
 - Updating in-patient ward processes to ensure that risk assessments are completed prior to periods of Section 17 leave.
 - Creation of a monthly liaison meeting between the local police and Tower Hamlets directorate to discuss concerns arising across in-patient and community services.
 - Updated communication sent to all clinicians highlighting how to contact police and the agreed processes.
8. Upon receiving your Regulation 28 report the Trust has reflected on your concerns and agrees that it must continue to improve its communication with the police. This is especially the case as the police force's dedicated mental health liaison workers have just been disbanded. This, alongside pre-existing limitations in information sharing between the Trust and the police and operational challenges associated with Right Care, Right Person will make joint working more difficult. To this end, on 1 May 2026, the Trust's Chief Executive Officer, Deputy Chief Executive Officer and Chief Medical Officer will be meeting with the MPS Lead Responsible Officer for Mental Health, other senior MPS officers and North East London NHS Foundation Trust to discuss how to best manage these changes and strengthen integrating working in future. The following items will be considered:
- More effective and direct operational liaison between mental health services and the Metropolitan Police Service.
 - Clearer shared expectations around risk escalation and safeguarding responses.
 - Practical steps to support frontline staff across our organisations to work confidently and collaboratively in high-risk situations.
 - How we can deliver training to front line police officers by mental health professionals.

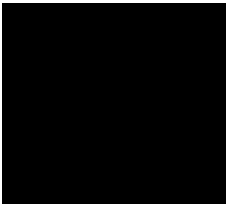


Conclusion

9. I hope this response provides sufficient reassurances to you and to the family of Ms Adeyelu about the learning that has taken place at the Trust since her sad death.

10. I would like to offer my sincere and heart-felt condolences to her family at this difficult time.

Yours sincerely



Chief Medical Officer

