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

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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	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** [redacted] **2. [redacted], Interim Chief Executive Officer, East London Foundation NHS Trust (ELFT)** [redacted] **3. [redacted], The Commissioner of Police of the Metropolis** [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 the 8 November 2022 I commenced an investigation into the death of Caroline Alaba Omotayo Adeyelu, aged 64 at the time of her death. The investigation concluded at the end of the inquest on 10 December 2025 with the jury reaching a narrative conclusion: *Caroline Adeyelu was unlawfully killed. A probable cause of her death was serious failures /inaction in care provided to the subject by ELFT and NELFT which contributed to her death. These consisted of insufficient communication regarding the transfer of care and inadequate engagement with Caroline's family for a broader risk assessment. Furthermore, despite a documented history of repeated violent incidents, no robust home risk assessments, safeguarding measures, or relapse plans were implemented for the subject or the family.* Due to the complexity of this inquest and the number of issues arising, interested persons were afforded additional time to provide written submissions on the issue of preventing future deaths. Hence the late publication of this Regulation 28 report.
4	**CIRCUMSTANCES OF THE DEATH** Caroline Adeyelu suffered a fatal stab wound to her chest at her home address on the 30 October 2022. The fatal injury was inflicted by her son who was suffering from a mental health disorder and who was under the care of the community mental health services at the time of her death. The jury made the following findings in relation to the public services involved with Caroline and her son: • The assessment of the subject's risk to others and the management of that risk by NELFT and ELFT following the discharge in October 2020 was inadequate. • The subject was discharged with a diagnosis of acute transient psychosis. • Despite Caroline informing NELFT that she was fearful of being around the subject, instead of referring the matter to the safeguarding team, Caroline was advised to issue an eviction notice to remove the subject from the home address. • Upon discharge, no risk or safety plan was provided to the family. No relapse or safety plan was created, despite clear indicators that she remained vulnerable and her concerns were not adequately taken into account. • In addition, the Staying Well Plan created by ELFT was not received by NELFT. This possibly contributed to Caroline's death, as the care co-ordinator was unaware of the warning signs laid out in the Staying Well Plan. • The sharing of information by ELFT following the subject's threat to kill in early 2021 was inadequate. Although the mental health team was aware, they failed to notify the police. Caroline reported receiving threatening messages, despite her not wanting to tell the police, the burden should not have been placed on her. • Insufficient steps were taken to assess the risk of the subject and to safeguard Caroline, when the subject moved back home in October 2021. • There was no home risk assessment/carer's assessment carried out despite previous serious concerns. • Care co-ordination by NELFT was inadequate. A proper relapse plan was not created; CPA reviews were missed and care co-ordinators lacked an in-person or written handover, resulting in gaps of vital information. • NELFT also responded inadequately to concerns that Caroline raised from 26 October 2022, onward. Concerns raised were not explored or escalated. A number of options were available to assist in keeping Caroline safe, but these were not taken. • There was a serious failure to review the subject's medical history. • Neither trust engaged sufficiently with other family members who could have given a broader overview of risks present.

	• As a result, despite a documented family history of violence and knife related incidents at home, no home risk assessment was conducted. No care plans or safeguarding measures were implemented. Risk management procedures were not initiated and responsibility for reporting serious threats was left with the family.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. It is noted that NELFT, ELFT and the MPS have all taken the circumstances of Caroline Adeyelu's death very seriously. They have all exhibited to the court a significant degree of reflection and willingness to learn from the tragic circumstances of this case. Many of the concerns raised during the course of the inquest have been addressed by the statutory bodies involved. In my opinion however there is a risk that future deaths could occur unless action is taken in the following areas. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: 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 home-based 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. 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.
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe you 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 **30 April 2026**. 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 am sending a copy of my report to the Chief Coroner, to the family of Caroline Adeyelu, to the CQC, to the local Director for Public Health and to NHS England. NHS England are receiving a copy of the report, as the concern about the extent of training for adult child to parent abuse may be of concern nationally (considering the Femicide Census figures). I am 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	**5 March 2026** [redacted]