



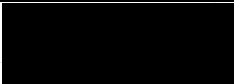
MISS N PERSAUD
HIS MAJESTY'S CORONER
EAST LONDON

EAST LONDON CORONERS, 124 Queens Road, Walthamstow, London E17 8QP

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1. [REDACTED] Interim Chief Executive Officer, East London Foundation NHS Trust (ELFT) [REDACTED]</p>
1	<p>CORONER</p> <p>I am Nadia Persaud, Area Coroner for the coroner area of East London</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On the 14 April 2022 I commenced an investigation into the death of Somtera Bibi, aged 80 at the time of her death. The investigation concluded at the end of the inquest on 23 April 2026, reaching a narrative conclusion:</p> <p><i>Mrs Somtera Bibi died as a result of stab wounds to the chest. The perpetrator was a family member who was suffering from a mental health disorder at the time of inflicting the fatal injuries upon her.</i></p>

4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Mrs Somtera Bibi received fatal stab wounds in her home address on the morning of 2 April 2022. Her life was pronounced extinct by a medical practitioner on scene. The fatal injuries were inflicted by her grandson who was suffering from schizoaffective disorder. The grandson had been under the care of the ELFT mental health services for many years. Despite a recurrent cycle of non-compliance with medication; relapse in mental health; violent and aggressive behaviour and detention in hospital, the patient was not cared for under a robust framework of mental healthcare whilst in the community. He was known to present as a risk to others when unwell and was known to frequently stop taking his medication. Despite this there was no relapse prevention plan and/or safety plan in place to safeguard members of his family living in the home address. There had been no Domestic Abuse Stalking and Harassment (“DASH”) risk assessments carried out by the mental health team, or safeguarding referrals by the mental health team when prior risk incidents occurred. There was no attempt by the mental health team to ensure multi-agency risk management or to involve the patient and his family in robust risk management. The evidence at the inquest did not reveal that such risk management would on the balance of probabilities have prevented Mrs Bibi’s death, but it is clear that there was a missed opportunity to attempt to safeguard her.</p>
5	<p><u>CORONER’S CONCERNS</u></p> <p>During the course of the inquest the evidence revealed matters giving rise to concern.</p> <p>In my opinion, 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.</p> <p>The MATTERS OF CONCERN are as follows:</p> <p>The patient/perpetrator was identified as being a risk to others when unwell. His risk assessment identified domestic abuse; sexual abuse; possession/preoccupation with weapons; threats to kill family members. The risk assessment noted a prior conviction for possession of a knife and threatening behaviour.</p> <p>Despite identifying the above risks over a period of many years, there was no relapse prevention plan; family safety plan or significant attempts to safeguard the family. Specifically:</p> <ul style="list-style-type: none"> (i) There was no adequate evidence of a response to multiple attempts by the police to formulate a safety plan for the family (ii) No advice was sought from the forensic psychiatric team in light of the previous conviction; nature of risk and assault on his mother in October 2020 (iii) No DASH risk assessment was completed or attempted, following incidents where family were harmed or threatened (iv) No attempts to involve the safeguarding or social care team to protect vulnerable family members (v) No relapse prevention plan/risk management plan, drawn up with the input of the patient and family members (vi) There was no risk assessment within the home environment with practical advice to the family on how to keep safe in the event of another violent relapse

6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 30 June 2026. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I am sending a copy of my report to the family of Somtera Bibi, to the CQC and to the local Director for Public Health.</p> <p>I am also under a duty to send a copy of the report and your response to the Chief Coroner and all interested persons who in my opinion should receive it.</p> <p>I may also send a copy of your response to any other person who I believe may find it useful or of interest.</p> <p>The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she believes may find it useful or of interest.</p> <p>You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.</p>
9	<p>2 May 2026 </p>