NHS
Whittington Health
NHS Trust

Medical Directorate
Jenner Building
Magdala Avenue
London N19 5NF

[redacted]

12 November 2026

To: Senior Coroner ME Hassell
Inner North London Coroner's Court

Dear Senior Coroner Hassell,

Response to Regulation 28: Prevention of Future Deaths Report

Regarding [redacted] (died 3 April 2026)

Thank you for your Regulation 28 report dated 21 September 2026 concerning the very sad death of [redacted]. On behalf of Whittington Health NHS Trust, I wish again to express our sincere condolences to [redacted] family.

The Trust has carefully considered the matters identified in your report and recognises the importance of reflecting on [redacted] care, identifying opportunities for learning and taking appropriate action to reduce the risk of similar events occurring in the future.

We have reviewed the clinical assessment and decision-making during [redacted] Emergency Department attendance on 27 March 2026, including the significance of her reported behavioural change, severe insomnia, recent commencement of sertraline, available support and the safety-netting arrangements. This response sets out the conclusions of those reviews, the areas identified for learning and the actions being taken.

1. Review of [redacted] Care

Prior to your hearing, on the 7th of August, [redacted] care and the circumstances of her death were reviewed at the Whittington Incident Safety Huddle (WISH) the Trust's multidisciplinary forum for reviewing patient safety events, with executive and patient

safety oversight. [redacted], Emergency Department Consultant, presented the case for discussion.

Following the issue of your report, a further review was undertaken by [redacted] Emergency Department Clinical Lead, and [redacted] Emergency Department Lead for Mortality, using a structured judgement review (SJR) approach. These reviews considered the contemporaneous clinical record and the decisions made on the information available at the time.

2. Clinical Presentation and Subsequent Events

[redacted] attended the Emergency Department on the night of 27 March 2026, reporting symptoms of insomnia, nausea for a few days, as well as an acutely stressful episode on that day, and requesting medication to help with sleep. Initial triage documentation described a screaming episode at work suggesting mania that evening, and recorded that she had previously reacted similarly to sertraline. The assessment documented a background of anxiety and depression, with recent commencement of sertraline prescribed by her psychiatry team [redacted]

At the time of her attendance, there were no acute medical concerns, no reported suicidal ideation and no documented evidence of psychosis. [redacted] was discharged with a three-day supply of promethazine and advice to seek urgent medical attention if she experienced suicidal thoughts or hallucinations. [redacted] was also advised to arrange a review her symptoms and medication with her GP. [redacted] was not referred to the mental health team on her attendance in the emergency department.

On 1 April 2026, [redacted] was found unresponsive outside her home and was transferred to the Royal London Hospital with severe traumatic injuries. Despite treatment, she sadly died on 3 April 2026 following brainstem testing. The recorded cause of death was traumatic brain injury.

3. Findings of the Clinical Reviews

The initial review at WISH considered [redacted] assessment and management during her Emergency Department attendance. WISH requested further clarification of aspects of [redacted] assessment and management, including whether referral to the Mental Health Liaison Team would have been indicated at the time of her presentation on 27 March.

The subsequent clinical review found that [redacted] had been appropriately triaged and had undergone a clear and documented clinical assessment, including consideration of her mental health symptoms and immediate risk. The review also identified opportunities for

more detailed exploration of her reported behavioural disturbance, significant insomnia and recent commencement of sertraline.

The case was discussed retrospectively with the Mental Health Liaison Team, whose view was that, based on the documented clinical presentation, the threshold for referral at the time of [redacted] Emergency Department attendance had not been met.

The reviews recognised that more detailed exploration of [redacted] presenting symptoms and circumstances may have provided a fuller understanding of her changing mental state and any additional risk or support needs. It was noted that there was no documentation of any collateral history from [redacted] flatmate, which may have provided additional information to inform the clinical assessment.

4. Learning Identified

The reviews identified four principal areas of learning relating to clinical assessment, medication advice, available support and specialist mental health input.

Assessment of behavioural change and insomnia

The reviews highlighted the importance of exploring and documenting significant behavioural change and insomnia, particularly where these may indicate a changing mental state.

Psychotropic medication and advice on discharge

The Coroner's report specifically highlighted that [redacted] was advised to seek a GP medication review without receiving explicit advice about whether to continue taking sertraline. The Trust recognises the importance of providing clear medication advice, particularly where a patient presents with symptoms potentially associated with recently commenced psychotropic medication. This case has reinforced the need to ensure that decisions regarding continuation or review of medication, the rationale for those decisions and the urgency of follow-up are clearly communicated and documented. This learning has been incorporated into the planned Emergency Department teaching programme.

Support networks and safety-netting

The reviews also highlighted the importance of establishing the practical support available to patients following discharge, including the involvement of family, friends or carers where appropriate, and ensuring that safety-netting advice and follow-up arrangements are clearly documented.

Specialist mental health assessment

Although the retrospective discussion with the Mental Health Liaison Team concluded that the documented presentation did not meet the threshold for referral, the reviews reinforced the importance of learning that support recognising when further specialist discussion may be appropriate, particularly if there is significant behavioural change or uncertainty regarding a patient's mental state.

5. Actions Taken and Planned

Regular teaching on the assessment of patients presenting with mental health problems is already established for Emergency Department doctors. The learning from [redacted] care has been identified for inclusion in this existing programme, under the oversight of the Emergency Department Clinical Lead.

This teaching will reinforce the importance of:

- Exploring and documenting behavioural change, significant insomnia and other features that may indicate a changing mental state.
- Considering the relevance of recently commenced or changed psychotropic medication, including clear documentation of medication advice and the rationale for that advice.
- Establishing and documenting the patient's available support network, arrangements for follow-up and appropriate safety-netting advice.
- Recognising circumstances in which further discussion with specialist mental health services may be appropriate.

Action	**Responsible lead**	**Completion date**
Share learning from [redacted] case through ED 10@10 teaching, covering behavioural change, insomnia, psychotropic medication and safety-netting	ED Clinical Lead	20th November and 18th December
Incorporate relevant learning into ED induction for incoming doctors	ED Clinical Lead	2nd of December

Confirm delivery and review implementation through established ED clinical governance arrangements including monthly patient safety meeting and Newsletter	ED Clinical Lead	Evidence of completion by December 31st

6. Governance and Assurance

The Trust will oversee the implementation of this learning through its established Emergency Department educational and clinical governance arrangements. The Emergency Department Clinical Lead will be responsible for ensuring that the learning is shared with the relevant clinical teams and that delivery of the planned teaching is recorded.

The learning identified through the WISH discussion and subsequent structured clinical review has therefore informed a defined programme of educational and governance actions, with named responsibility and completion dates.

Conclusion and Commitment

We recognise the importance of the concerns raised in your report and are committed to ensuring that the learning from [redacted] care informs our clinical practice and contributes to the ongoing improvement of care for patients presenting with mental health concerns.

We recognise the profound loss experienced by [redacted] family and friends and extend our sincere condolences to them once again.

Yours sincerely,

[redacted]

[redacted]

Chief Medical Officer
Whittington Health NHS Trust