RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS
REGULATION 29 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

THIS RESPONSE IS BEING SENT TO:

Nadia Persaud His Majesty's Coroner, for the coroner area of East London in response to a 'REPORT TO PREVENT FUTURE DEATH REGULATION 28' following an inquest into the death of Miriam Laird (nee Camilleri), which concluded on 6 August 2026.

1.	**RESPONDENT** In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, [redacted], Chief Executive Nurse and Executive Lead for Patient Safety at North East London NHS Foundation Trust, provides this response within 56 days (plus any extension granted) of the date of the Report to Prevent Future Deaths.
2.	**DATE OF RESPONSE** 9 October 2026
3.	**CONFIRMATION OF CORONER'S MATTERS OF CONCERN** The **MATTERS OF CONCERN** are as follows: (1) There was a lack of attention to risk formulation and to risk management at times where risk to self clearly appeared to be increasing. (2) The child safeguarding referral appears to have been made automatically without any proper enquiry into the circumstances of the child. (3) There was a lack of multi-agency support provided to a mental health patient in crisis, to assist her in navigating the consequences of a child safeguarding referral.
4.	**DETAILS OF ACTIONS TAKEN** **Concern 1** ***There was a lack of attention to risk formulation and to risk management at times where risk to self clearly appeared to be increasing*.** In addition to the two learning events that took place with the crisis services following Miriam's death to support embedding Risk Formulation and the identification of escalating risk, the Home Treatment Team (HTT) is also ensuring documentation of risk information immediately following discussions at handover meetings. These are also reviewed at the weekly Clinical Review Meetings that take place where all patient risks are reviewed. In cases where increasing levels of risk are identified, patient reviews and assessments are conducted exclusively by qualified members of the clinical team. Following the review of patients, the risk management and safety plans are updated and consideration given to appropriate intervention and enhanced level of care.

	Weekly Risk Formulation sessions are provided by psychologists within the RHTT for complex patient presentations. These sessions support the development of clinical expertise and confidence in formulating risk profiles and identification of escalating risk. This will ensure that risk assessments are translated into meaningful and actionable safety plans. HTT are also undertaking case reflection using this incident to reinforce expectations regarding risk assessment, identification of escalating risk, documentation and response to missed or rearranged clinical contacts. These actions are scheduled for completion by 30 September 2026. The Trust recognises there is additional work to do to fully embed Risk Formulation and associated Safety Plans. The Trust programme has been addressing the uptake and implementation of this approach to risk. The current phase of the programme is focusing on: **Measuring the impact of risk formulation** Through audits, patient and staff feedback, and safety data. This work is ongoing. **Implementing a standardised audit processes across all services**. The risk formulation tool for adults is being finalised and was discussed at the Risk Formulation strategy group on 15.09.2026. It will be implemented and monitored locality. **Developing reporting dashboards (Power BI/InPhase) to monitor outcomes** These are in place and are monitored through NELFT governance process. **Finalising and embedding the Trust-wide safety plan** This will commence on 04/10/2026. The current Crisis Management and Contingency plan on RiO will be replaced by the Safety Plan. **Determining refresher training requirements** Safety planning is now an integral component of Risk Formulation training. Greater emphasis and visibility have been given to this area within the Risk Formulation refresher training which is scheduled for rollout from 28 October 2026. The training will adopt an experiential learning approach, incorporating case studies to facilitate reflective practice and strengthen the application of risk formulation principles in clinical setting studies. As part of the **Patient and Carer Race Equality Framework (PCREF)**, we are also undertaking work to strengthen how culture, identity and social context are considered

within Risk Formulation and clinical practice.

Concern 2
The child safeguarding referral appears to have been made automatically without any proper enquiry into the circumstances of the child

The safeguarding alert was raised following information disclosed during Miriam's initial assessment in the Emergency Department. During the assessment, Miriam reported that she was temporarily staying with her parents and intended to remain there for approximately one week before returning to Kent to care for her daughter. She also expressed concerns about her ability to manage the care of her nine-year-old daughter while simultaneously meeting her own support needs. These discussions, alongside her stated plans to return to her daughter, contributed to the decision to raise a safeguarding alert.

The safeguarding alert was submitted to the appropriate social care service in Kent, where it was reviewed and triaged in accordance with their local safeguarding procedures.

The safeguarding alert was submitted by Whipps Cross (Barts Health) staff, and the details of the information contained within the referral are not available. It would have been beneficial for the referral to reflect Miriam's stated concerns that her mental health presentation might impact her ongoing access to her daughter, as this formed an important aspect of her risk. We have liaised with Bartshealth to understand better their training around raising safeguarding alerts.

NELFT's internal actions are captured below as Concerns 2 and 3 overlap.

Concern 3
There was a lack of multi-agency support provided to a mental health patient in crisis, to assist her in navigating the consequences of a child safeguarding referral

Kent Social Services contacted Miriam at home following the referral from Whipps Cross and this caused her additional distress.

In order to ensure multi-agency support to patients in crisis, NELFT staff will be reminded of the requirement to undertake follow-up activity within 72 hours of a safeguarding referral. This enables any emerging information or concerns to be shared promptly with partner agencies. In this instance, such follow-up could have reinforced Miriam's expressed concerns regarding the possibility of her daughter being removed from her care and her worries that her mental health difficulties might be cited in relation to future custody considerations. The two organisations could have worked together to reassure Miriam and to work together to ensure her contact with her daughter.

	Further awareness is required regarding how referrals are raised; sharing information and ensuring understanding (where appropriate) for the service user regarding the purpose of the safeguarding and the support that will be forthcoming following this and how health and social care agencies continue to work together to support the service user and their children. In order to address this further bespoke ThinkFamily approach training will be delivered to all crisis services by 30.11.2026. The safeguarding policy is currently being reviewed and we will ensure that the points identified above are reflected in the policy. A seven minute briefing will also be shared with all NELFT staff to share the learning identified above.
5.	**DETAILS OF FURTHER ACTION PROPOSED** In addition, NELFT acute and rehabilitation directorate has recently developed an action plan that works with safeguarding partners to strengthen inter-agency communication through timely information sharing, clear escalation pathways, and improved follow-up processes. Consideration has been given to opportunities for joint learning, multi-agency case discussion, and the development of agreed communication standards to support collaborative decision-making and ensure that relevant information regarding an individual's circumstances, concerns, and risks is effectively shared and understood by all agencies involved The Trust will use a number of established mechanisms to support the implementation, spread and sustainability of learning, including: • the Culture of Care Collaborative; • the Trust's Quality Improvement Programme and Quality Improvement Fora; • clinical governance and patient safety processes; • safeguarding governance arrangements; • Trust-wide learning briefs and thematic reviews; • workforce development, supervision and reflective practice; • the development and embedding of the Trust's Quality Management System, supported through partnership with the Institute for Healthcare Improvement (IHI).
6.	**SIGNATURE** 