Regulation 28: Prevention of Future Deaths report

Mariana Hungria Bayam Veiga PINTO (died 16.10.16)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Medical Director** **East London NHS Foundation Trust** **Trust Headquarters** **9 Alie Street** **London E1 8DE**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 19 October 2016, I commenced an investigation into the death of Mariana Hungria Bayam Veiga Pinto. The investigation concluded at the end of the inquest on 13 March 2017. I made a narrative determination at inquest, which I attach. I recorded the medical cause of death as: 1a multiple injuries including ruptured left kidney.
4	**CIRCUMSTANCES OF THE DEATH** Mariana Pinto jumped from the third floor balcony of her home as a deliberate act, but without a proper understanding of what she was doing.

	She had attended the emergency department of the Homerton University Hospital the day before and had been assessed as not detainable under the Mental Health Act. On the day of her death, her husband called the City and Hackney Crisis Line at lunch time and was told that she would receive a home visit between 5 and 7pm. He then called back at 3.32pm, explaining that his wife was deteriorating rapidly and needed to see someone urgently. Half an hour later, Mariana Pinto jumped.
5	**CORONER'S CONCERNS** During the course of the inquest, the evidence revealed matters giving rise to concern. In my opinion, there is a risk that future deaths will occur unless action is taken. In the circumstances, it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. 1. It seemed to me at inquest that, when Ms Pinto left the emergency department the day before her death, the limitations of the crisis team were not made clear to her family and friends. 2. The view of the psychiatrists treating Ms Pinto in the emergency department was that she was suffering cannabis withdrawal, which I heard is generally at its worst during the first three days. Her symptoms were now quiescent, but it would have been very helpful for her family to know that, most particularly as she had taken cannabis the night before, once the lorazepam wore off she might well have a resurgence of symptoms *though these were not expected to be as severe as they had been*. Worsening advice could then have been delivered in this context, with a clear plan of action. It is a theme I have noticed in deaths such as Ms Pinto's, that clinicians' expectations of illness progression are not necessarily communicated effectively to families, to enable families to identify unexpected deterioration and then to act swiftly and appropriately. 3. The band 7 mental health nurse who took the call to the crisis line at 3.32pm on 16 October, did not suggest to Ms Pinto's husband that [redacted] call the emergency services while the nurse rang Ms Pinto and spoke to her to offer what support he could. When [redacted] told him that the situation was now *urgent*, the nurse responded that the time for home visits was 5-7pm.

	After the call had ended, the nurse did not discuss with colleagues the potential to bring the home visit forward. The nurse did not ring the emergency services himself in case [redacted] had been unable to make the call.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 22 May 2017. 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 have sent a copy of my report to the following. • HHJ Mark Lucraft QC, the Chief Coroner of England & Wales • Care Quality Commission for England • [redacted], psychiatrist, City & Hackney • [redacted], emergency physician, Homerton Hospital • [redacted], crisis team member • [redacted], crisis team member • [redacted], husband of Mariana Pinto I am also under a duty to send the Chief Coroner a copy of your response. 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

9	**DATE** 14.03.17	**SIGNED BY SENIOR CORONER**