Regulation 28: Prevention of Future Deaths report

Fallon Alphonsine ABBY (died 19.02.17)

	THIS REPORT IS BEING SENT TO: **1. Dr Kevin Cleary** **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 February 2002, one of my assistant coroners, Heather Williams, commenced an investigation into the death of Fallon Abby, aged 18 years. The investigation concluded at the end of the inquest on 7 August 2017. I made a determination of suicide, when Fallon jumped from the balcony of her sixth floor bedroom at around 10.45pm on Saturday, 18 February 2017, while two members of the ambulance service were attempting to persuade her to go to hospital for treatment.
4	**CIRCUMSTANCES OF THE DEATH**

	Fallon had attended the emergency unit at the Royal London Hospital a week before her death following an intentional overdose, then re-presented with alcohol toxicity. She was admitted to Roman Ward of Mile End Hospital because she was thought to be at high risk of suicide. She was discharged to the care of the home treatment team on Thursday, 16 February 2017.
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. I heard at inquest that no member of the team on Roman Ward contacted Fallon's social worker. There was no protocol for this. If they had sought a collateral history from the social worker, they would have discovered that Fallon's mum was not dead as Fallon had told them, but was alive and living in a hostel. The social worker had been rung by a nurse at the Royal London Hospital, but she was waiting to be invited to a ward round at Mile End Hospital and such invitation was never made. It seems unlikely that proper discussion with the social worker would have changed the outcome for Fallon, but it would have meant that valuable information would have been shared, and it would have meant that Fallon would have had the benefit of her social worker on hand upon discharge. This might be very important for another patient.
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 9 October 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], sister of Fallon Abby • [redacted], sister of Fallon Abby 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** **SIGNED BY SENIOR CORONER** 08.08.17