REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Professor Oliver Shanley, Interim Chief Executive, North East London Foundation Trust, Goodmayes Hospital, Goodmayes, 157 Barley Lane, Essex, IG3 8XJ
1	**CORONER** I am Nadia Persaud, Senior Coroner for the Coroner area of East London
2	**CORONER'S LEGAL POWERS** 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/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 5th October 2018 I commenced an investigation into the death of Karis Florence Braithwaite. The investigation concluded at the end of the Inquest on the 17th September 2019. The conclusion of the Inquest was a narrative conclusion: *Karis Braithwaite took her own life, in part because of the risk of her doing so was not adequately assessed and appropriate precautions were not taken to prevent her from doing so.*

4	**CIRCUMSTANCES OF THE DEATH** Karis Braithwaite was 24 years old. She suffered from recurrent depressive disorder and emotionally unstable personality disorder. Karis had a long history of self-harming behaviour. She also had a history of suicide attempts. On the evening of the 23rd September 2018, Karis was involved in a disagreement with a resident in her supported accommodation. She struck the resident and then shortly afterwards left the home. She went straight to the Dagenham Heathway railway station where she stepped on to the track in the path of an oncoming train. Members of the public had to intervene. The driver performed an emergency stop and Karis had to be pulled off the track by bystanders. Paramedics attended and the Inquest heard evidence from a paramedic who considered Karis's presentation to be very different to previous occasions on which she attended to her. She confirmed that Karis had voiced a clear intention to take her own life on the 23 September 2018. Karis was taken to hospital by police and paramedics under section 136 of the MHA. The paramedic confirmed that she attempted to provide a clear verbal handover to staff, as well as providing her written concerns on her Patient Report Form ("PRF"). The paramedic's evidence was that the staff were not very receptive to a verbal handover. Some aspects of the PRF form were carried over into the Trust's electronic records but none of the detail containing the mental health risks were incorporated into the Trust's records. Karis underwent assessments by two doctors in the early hours of the 24th September 2018. It was decided that she would need a period of rest and emergency housing options to be checked before her final MHA assessment. The following day, Karis underwent the Section 136 MHA Assessment. She was assessed by two consultant psychiatrists, an approved mental health practitioner and a member of the home treatment team. The team spent 27 minutes with Karis before spending a further 2 minutes to confirm their conclusion. The team considered the electronic RIO records but did not have sight of any verbal handover record from the paramedic or the PRF form from the paramedic. At 14:30 on the 24th September 2018 Karis was discharged from the Section 136. She left the hospital in contravention of the suggested plan for her to take a taxi back to her supported accommodation. She alighted 2 buses to Goodmayes railway station. She stood in front of a non-stopping fast train at 15:28 and sustained fatal multiple injuries.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: 1. Important risk information was provided to the Trust by a first responder (paramedic) but was not available to the MHA assessment team. 2. A copy of the PRF form was left with staff but does not appear to have been uploaded to the electronic records or a paper copy provided to the assessing team. 3. The paramedic provided a verbal handover to staff which does not appear to have been documented in the patient's records. 4. The police officer who attended with Karis also gave evidence as to difficulties in providing a handover to the receiving mental health team. 5. A PFD report was written to the Trust on the 2nd December 2016 noting: *There was also relevant information available to the paramedics and police that was not elicited by the assessing team.* *It became apparent during the course of the Inquest that the police also had access to information which was relevant to the circumstances of the preceding events which would have been relevant to the mental state of the deceased. It would appear that inadequate questions were asked by the receiving hospital team in relation to the circumstances leading to admission.*

	In light of the evidence heard at Ms Braithwaite's inquest, there is a concern that insufficient steps have been taken by the Trust to improve the handover process from first responders to Trust staff following serious incidents in the community.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 **14th November 2019** 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 Chief Coroner and to [redacted] (mother of the deceased). I am also forwarding a copy to the Care Quality Commission, to the Director of Public Health and to the London Ambulance Service 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 coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**[DATE]** 20.9.19 **[SIGNED BY CORONER]**