REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Professor Oliver Shanley, Interim Chief Executive, North East London Foundation Trust, Goodmayes Hospital, Barley Lane, Goodmayes, Ilford, 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 22nd February 2018 I commenced an investigation into the death of Samantha Louise Higgins. The investigation concluded at the end of the Inquest on the 20th November 2019. The conclusion of the Inquest was a narrative conclusion: *Sammi Higgins suffered from emotionally unstable personality disorder, anxiety, depression and mood congruent psychosis. Her mental state had been deteriorating over the 10 months leading up to her death. Her presentation was characterized by overwhelming voices telling Sammi to harm herself. Sammi was under the mental health services throughout this period of time, but no overarching care plan was in place and she had no key-worker assigned to her. There was no assigned member of the mental health team with responsibility to ensure that Sammi's care plan was actioned. Sammi was deemed to be at moderate to high risk of suicide in early January 2018. It was considered that her anti-psychotic medication needed to be changed as a priority. The change of medication was not communicated to the GP and no steps were taken to ensure that the medication change took place. On Friday the 2nd February 2018, Sammi presented to the mental health team after taking an overdose of medication and self-harming by cutting. She was deemed to be a low risk of suicide by the assessing nurses and discharged home with no mental health support offered over the weekend. On Saturday 3rd February 2018 Sammi ingested a fatal combination of alcohol and tablets. Sammi took the action that lead to her death. Her intention at the time of this action is unknown due to the effect of the overwhelming voices upon her ability to form an intention.*
4	**CIRCUMSTANCES OF THE DEATH** See above narrative conclusion.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows:

	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. Sammi was cared for under the Access Assessment and Brief Intervention Team (AABIT). She was under the care of this team for almost three years. Her care requirements went beyond "brief intervention". Whilst under the care of this team, Sammi had no overarching care plan. No-one was appointed to oversee Sammi's care. The evidence at the Inquest revealed that doctors working within the team were not aware of the possibility of service users under the AABIT having an overarching care plan or of service users having a key-worker assigned to them. 2. Sammi suffered from emotionally unstable personality disorder and mood congruent psychotic symptoms. She required psychotherapy treatment. She was referred to the psychotherapy services in March 2017. By the time of her death in February 2018, Sammi had not received psychotherapy. The Inquest heard that there could be delays of 17 months from referral to receipt of treatment. It is considered that these ongoing lengthy delays give rise to a risk of future deaths.
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 **5 February 2020**. 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] (on behalf of the family), Matthew Cole (Director of Public Health), the CQC and to the Metropolitan Police Service Legal Team 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	**13/12/2019**