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 23rd October 2019 I commenced an investigation into the death of Lee Leslie Carpenter. The investigation concluded at the end of the Inquest on the 25th February 2020. The conclusion of the Inquest was a narrative conclusion: *Mr Carpenter took his own life on the 1st October 2019. He had been referred by his GP to the mental health services on the 9th August 2019. The GP requested an urgent review and had to send a second referral on the 10th September 2019. There was lack of robust risk assessment, care planning and medication review following the GP referral. Mr Carpenter's mental state declined considerably from the 24th September 2019 with numerous high risk incidents. He was assessed by the Home Treatment Team 30th September 2019 but not deemed to meet the criteria for admission to hospital. He was accepted for care by the Home Treatment Team, as the least restrictive option available. When he was visited at around 11 am on the 1st October 2019 by the Home Treatment Team there was no response from him. The alarm was not raised by the team at that time. Mr Carpenter was found deceased in his home address by his family in the early afternoon on the 1st October 2019.*
4	**CIRCUMSTANCES OF THE DEATH** See narrative conclusion in box 3 for detail.
5	**CORONER'S CONCERNS** The matter of concern during the course of the Inquest, was that a GP had made a referral to the mental health team requesting an urgent review of Mr Carpenter. This was sent on the 9th August 2019 to the Havering Access Assessment and Brief Intervention Team. The referral was received on the same date and appears to have been triaged for a non-urgent response. The decision determining the non-urgent response was not documented. There was no documented rationale for overriding the GP's request for an urgent review. There was no discussion with the patient or the GP before the decision to downgrade the urgency. The member of staff who made the decision was not identified within the medical records. The first telephone assessment of Mr Carpenter did not take place until the 23rd August 2019.

	As at the date of the Inquest, there is no system in place within the Trust for the important clinical decision relating to the triage of GP referrals to be clearly documented within patient records and for the member of staff making the decision, to be clearly identified and accountable.
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 **27 April 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 the family of Mr Carpenter. I am also forwarding a copy to the Care Quality Commission and to the Director of Public Health 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** 3.3.2020 **SIGNED BY CORONER**