East London Coroners
MISS N PERSAUD
SENIOR CORONER
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
Telephone 020 8496 5000 Email coroners@walthamforest.gov.uk

REF: [redacted]

12th November 2020

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Secretary of State for the Home Department 2 Marsham Street London SW1P 4DF United Kingdom public.enquiries@homeoffice.gov.uk **2.** The Commissioner of Police of the Metropolis Metropolitan Police Service New Scotland Yard Broadway London SW1H 0BG new.scotland.yard@met.police.uk
1	**CORONER** I am Mr Graeme Irvine Area Coroner for **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/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 11th March 2020 I opened an investigation touching the death of Chelsie Violet Greatorex, aged 18 years old. I opened and inquest on the 27th March 2020. The inquest concluded on the 2nd November 2020. The conclusion of the inquest was accidental death.

	The record of inquest stated, "On 10th March 2020, Ms Chelsie Violet Greatorex took an accidental but fatal overdose of prescribed medication, despite emergency medical treatment she died at 17.35 hours." The medical cause of death was; 1a Propafenone and Flecainide poisoning
4	**CIRCUMSTANCES OF DEATH** Ms Greatorex was diagnosed with Ventricular tachycardia in December 2015 and was prescribed both Propafenone and Flecainide. Chelsie Greatorex was a victim of a sexual assault on 27th June 2019 at that time she was 17 years of age. The allegation was investigated by PC [redacted], an ERPT officer, from [redacted] refers). On 4th March 2020, Ms Greatorex tried to contact PC [redacted] without success. PC [redacted] contacted Ms Greatorex on 9th March 2020 when Ms Greatorex explained that the purpose of her call on 4/3/20 was that she felt low. The officer signposted Chelsie to Newham Talking Therapies (NTT). On 10th March 2020 Chelsie took a deliberate overdose of her prescribed medications and sustained a cardiac arrest. Despite emergency paramedic and medical treatment she died later that day at 17.35.
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. – a. Evidence heard in the inquest suggested that Ms Greatorex felt anxiety regarding her role as a complainant in a sexual assault trial. b. Despite the fact that Ms Greatorex was a child when the events of the allegation took place, the investigation was not conducted by a specialist officer or team. c. Delays in the investigation were identified, • despite naming the suspect and their place of study, no interview took place for over 3 months. • a decision to prosecute was not arrived at until late December 2020. • A court hearing was not listed until January 2020. d. When Ms Greatorex sought support from the MPS, no contact was made for four days, even then, the extent of the support was an email with the contact details of a borough psychological support service.

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 by **7th January 2021**. 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, to the family of Ms Greatorex, and The Survivors' Trust. 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	11/11/2020 Signature_____ Mr Graeme Irvine Area Coroner **East London**