MISS N PERSAUD
HER MAJESTY'S CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] **Medical Director, North East London Foundation Trust, Suite 1, Phoenix House, Christopher Martin Road, Basildon, Essex, SS14 3EZ** [redacted]
1	**CORONER** I am Nadia Persaud, Area 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/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 29th November 2018 I commenced an investigation into the death of Neil Challinor-Mooney, age 51 years. The investigation concluded at the end of the jury inquest on 12th May 2021. The conclusion of the inquest was that Neil died as a result of suicide contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Neil Challinor-Mooney suffered an acute relapse in his mental health in late October 2018. He required admission to hospital under the provisions of the Mental Health Act on the 1st November 2018. Shortly after his admission to hospital, his trainers were removed from him as part of risk management. There was no documentation around the removal of the trainers. At some point during the course of admission to hospital (1st

	November to 16th November 2018) Neil's trainers were returned to him. There was no documentation as to when the trainers were returned or any documentation around risk assessment or risk management relating to the decision to return the trainers. On the 13th November 2018 Neil disclosed in a ward round that he was having suicidal thoughts and that he would use his shoe laces to hang himself. The risk assessment and risk management plan was not updated as a result of this disclosure. Neil repeated this disclosure to a junior psychologist on the 14th November 2018. The psychologist disclosed the suicidal ideation and the plan to the senior nursing team. An action was documented for Neil's shoes to be removed, but this was never carried out. On the 16th November 2018 Neil was found suspended by the laces of his trainers. He was in an unconscious state. Sadly, he passed away at Queens Hospital on the 18th November 2018.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – The Inquest heard evidence that the Trust policy in relation to risk assessment and risk management is sufficiently clear, however the Court was not fully satisfied that the said policy had been fully embedded into practice. A number of nursing staff, including senior nursing staff, during the course of the admission, failed to follow the policy. Another concern arising during the course of the Inquest related to the integrity of the electronic records. The Inquest heard that medical records should be validated very shortly after being entered into the system. The Court saw evidence of multiple entries where there was a significant delay between original entry and validation. Amendments were made to the records after Neil had passed away, but these were not apparent on the records disclosed to the Court. An audit of the records had to be carried out before the amendments were exposed.
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 **15 July 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 and to the following Interested Persons the family of Mr Challinor-Mooney, the CQC and to the local Director of Public Health. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**[DATE] 20 May 2021**