MR G IRVINE
ACTING SENIOR CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], Chief Executive, London Borough of Redbridge Lynton House, 255 - 259 High Road, Ilford, IG1 1NY [redacted] 1. Department of Health & Social Care [redacted]
1	**CORONER** I am Graeme Irvine, acting 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/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 5th April 2021 I commenced an investigation into the death of Mrs Helena Opuku, aged 67 years. The investigation concluded at the end of the inquest on 8th October 2021. The conclusion of the inquest was that Mrs Opuku died from; 1.a Inhalation of Products of Combustion A Narrative conclusion was arrived at

4	**CIRCUMSTANCES OF THE DEATH** Mrs Helena Opoku was pronounced deceased on 4th April 2021 at her home address, she died as the result of carbon monoxide toxicity. Mrs Opoku had used charcoal braziers in her home to cook and provide heat. Both gas and electricity had been disconnected in her home. On 7th January 2021 a safeguarding alert, regarding the risk to Mrs Opoku of self-neglect, was raised whilst she was an inpatient receiving treatment for injuries sustained in a road traffic collision. Following discharge from hospital on 14th January 2021 social services neither assessed Mrs Opoku, nor her home. Social services did not allocate Mrs Opoku a social worker until 1st April 2021, at the time of her death that social worker had not made contact with Mrs Opoku.
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. – 1. During January- March 2021 the London Borough of Redbridge social services adult social care team in Cranbrook and Loxford were unable to; properly investigate all but the most acute safeguarding referrals made to them. 2. During the same period the team was unable to appoint social workers to vulnerable persons within a reasonable timeframe or carry out assessments of the suitability of the homes of vulnerable residents.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 **8th December 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 Mrs Opuku and to the Director for Public Health [redacted]. 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] 12th October 2021 [SIGNED BY CORONER]**