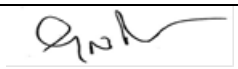
MISS N PERSAUD
SENIOR CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
Telephone 020 8496 5000 Email coroners@walthamforest.gov.uk

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: 112405

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Professor [redacted], Interim Chief Executive, North East London Foundation Trust, Goodmayes Hospital, Barley Lane, Goodmayes, Ilford, Essex, IG3 8XJ – Email: [redacted]@nelft.nhs.uk
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/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 30th July 2020 I commenced an investigation into the death of Trinder Kaur Birdi, 34 years old. The investigation concluded at the end of the inquest on 17th November 2020. The conclusion of the inquest was a narrative conclusion: *Trinder Birdi had a history of depression and personality disorder. She presented with low mood to her general practitioners from the 16th January 2020. On the 29th January 2020 she presented to her general practitioner and reported having taken two paracetamol overdoses in the past two days. Her general practitioner assessed her as high risk of suicide and referred her for an urgent psychiatric assessment in A & E. Ms Birdi was seen by a psychiatric nurse on the same day who reduced the risk of suicide to low. Ms Birdi reported to the nurse that she no longer wished to harm herself. A non-urgent referral was made to the Community Mental Health Team. On the 12th February 2020 Ms Birdi was taken to hospital in acute liver failure. Maximum medical therapy was provided but she did not recover. She passed away from the likely effect of drug toxicity*

	(self-administered). She was not seen by the Community Mental Health Team following the non-urgent referral on the 29th January 2020.
4	**CIRCUMSTANCES OF THE DEATH** See narrative conclusion above.
5	**<u>CORONER'S CONCERNS</u>** 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 general practitioner who had known Ms Birdi over a number of years and had seen her for multiple mental health consultations had raised concerns with the A & E psychiatric team that Ms Birdi was at a high risk of suicide. The GP considered that Ms Birdi required an urgent psychiatric assessment and that Ms Birdi was at a high risk of taking a further overdose with a higher number of tablets. Following assessment, the same day, by a psychiatric liaison nurse who had never met the deceased before, the risk to self was reduced to low. The risk was lowered from high to low, without any consultation with the general practitioner or second opinion sought and documented from a fellow psychiatric professional. It is concerning that the risk to self can be downgraded by a member of staff, new to the patient, following referral from a doctor who knows the patient well. There were no safeguards in place for this circumstance, such as a discussion with the referring general practitioner, second opinion from a fellow psychiatric clinician or assessment by a psychiatric doctor.
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 **20th 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 and to the following Interested Persons [family of Ms Birdi] I have also sent it to the CQC and the Director of Public Health who may find it useful or of interest. 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: 25/11/2020**  **(Ms Nadia Persaud)**