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HER MAJESTY'S CORONER
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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • [redacted], **Chief Executive, Barts Health, Royal London Hospital, Whitechapel Road, Whitechapel, London, E1 1BB** [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 11th December 2020 I commenced an investigation into the death of Vijaykumar Girishbhai Gadhavi, age 33. The investigation concluded at the end of the inquest on 16th December 2021 with a narrative conclusion. The narrative conclusion was that: *Vijaykumar Gadhavi died as a result of a drug overdose whilst he was an in-patient in hospital. He had a known risk of overdosing on hospital wards and had been placed under enhanced care (one to one supervision). There were numerous breaches of the enhanced care policy during the shift when Vijay was able to take the fatal, excessive amount of medication. The evidence does not reveal precisely how and when Vijay took*

	the drug overdose. There is no evidence that he intended to bring about his death at that time.
4	**CIRCUMSTANCES OF THE DEATH** Mr Gadhavi suffered from chronic pancreatitis, mild learning disability and possibly a persistent somatoform pain disorder (the latter was under investigation at the time of his death). In July and August 2020, whilst an in-patient at Whipps Cross Hospital and whilst under enhanced (1:1 care), Mr Gadhavi carried out a number of self-harming acts. These included overdoses and an attempt to jump from a hospital bridge. On one occasion in August 2020, the member of staff allocated to provide 1:1 care to him, was found to be sleeping. In September 2020, Mr Gadhavi required admission to Whipps Cross Hospital again. There was no alert on his medical records to alert staff to the need for a risk assessment and risk management plan. Fortuitously, he was recognised by a member of staff who had cared for him previously and enhanced care was put in place. Unfortunately, there were a number of breaches of the enhanced care policy. Mr Gadhavi was able to take a fatal overdose of medication whilst he was in in-patient on the ward.
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. Datix reports were generated for the multiple self-harming incidents in July and August 2020. There was no evidence at the inquest, that action and learning had been put in place as a result of these incidents. 2. Despite the multiple risk incidents and foreseeability of future hospital admissions, there was no alert or flag placed on Mr Gadhavi's records to alert new staff to the complexities and risk in his presentation. 3. Despite awareness of the previous overdoses on the ward, there was no itemised property list, including a list of medications. 4. The recommendations by the learning disability nurse were not fully put into practice. In particular, there was insufficient involvement of his family. 5. There were multiple breaches of the Enhanced Care Policy. There was no risk assessment by the allocated nurse; no consideration of the need to break up the shift of the 1:1 carer and no hourly observations kept by the 1:1 carer.
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 **26 April 2022**. 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 am sending a copy of my report to the Chief Coroner, to the family of Mr Gadhavi, the CQC, the local Director for Public Health and to North East London Foundation Trust.

	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	**28 February 2022 [SIGNED BY CORONER]**