Bhatt Murphy Solicitors

Coroner concludes that gross failings and neglect contributed to death of Donna Neill

14 September 2022

Before HM Senior Coroner Ms Nadia Persaud
East London Coroner's Court

5 - 8 September 2022
Conclusion on 13 September 2022

Donna Neill was reported dead on 10 December 2018 in her flat in East London. Toxicology reports indicated that she had fatally ingested oxycodone and pregabalin, her husband Martin's prescribed medication. After hearing four days of evidence, HM Senior Coroner returned her conclusions on 13 September 2022. She found that Donna was living hazardous conditions and that failings on the part of Donna's husband, the London Borough of Newham (LBN) and the East London Foundation NHS Trust (ELFT) all contributed to her death. She also indicated her intention to make a report to prevent future deaths around the failure by ELFT to document, assess and manage the risk around Donna's ingestion of unprescribed medication.

Donna was a 45 year old woman with complex needs. She had mild learning disabilities, a diagnosis of emotionally unstable personality disorder and was addicted to crack cocaine. She also had a number of physical conditions including diabetes and had a complex medication regime. She came under the care of Adult Social Care at the London Borough of Newham and community mental health services at ELFT. She was vulnerable to the risk of neglect and exploitation.

Donna had been married to her husband Martin since 1998, and although they were no longer in a romantic relationship, Martin continued to be Donna's carer and was entirely responsible for her medication and care needs. It was recognised that he was reliant on her for his benefits and that there had been a history of domestic abuse. From July 2018 evidence mounted that Donna's flat was being used as a crack house and the Metropolitan Police and the Anti Social Behaviour Team from LBN believed that Martin was the main culprit for bringing drug users into the house. Despite this, Donna's allocated social worker from the London Borough of Newham and care coordinator from the Trust maintained the view that Martin was an appropriate carer for Donna.

From August 2018 a closure order was imposed on the property prohibiting anyone other than Donna and Martin from entering the property. This was repeatedly breached with neighbours regularly complaining that the flat was being used as a crack house. By November 2018 a decision had been made to evict Martin from the property, although this was opposed by Donna's social worker who considered that Donna would be more vulnerable without Martin, and that as Donna had capacity she was making an informed choice about her lifestyle.

On 4 December 2018 Donna had a CPA meeting with her psychiatrist, social worker and care coordinator. Her psychiatrist noted concerns about Donna's ability to retain information about her medication. Despite this, no attempt was made to assess Donna's capacity to consent to her treatment. It was also noted that Donna was taking Martin's prescribed pain relief medication. Martin admitted having no up to date medication at home. Although Donna and Martin were told not to allow Donna to take Martin's medication, there is no evidence that this risk was documented, assessed or any plan was put in place to address it.

In the early hours of 10 December 2018 Martin called London Ambulance Service to report that Donna had been found unresponsive in her bed. Police attended and considered the death to be suspicious in light of the state of the flat, the large amount of medication which was all over the bedroom and the inconsistent accounts from Martin including that he had not seen Donna for 28 hours despite being in the flat the entire time. Neighbours reported the sounds of people coming in and out of the flat all weekend. The scene was secured but a CID officer decided that the case was not suspicious and therefore no forensic samples were taken from the scene. The family continued to have suspicions that Martin had deliberately administered his prescription medication to Donna.

On 3 July 2019 Assistant Coroner Ian Wade conducted the inquest into Donna's death. He called no witnesses and concluded that Donna had capacity and had made an informed decision to consume an excess of oxycodone and had died of an inadvertent overdose. Donna's mother issued judicial review proceedings of the conclusion and the inquest was quashed by the High Court by Order dated 17 December 2019. A new inquest was ordered and the matter allocated to HM Senior Coroner Nadia Persaud. In a written ruling dated 9 November 2021 she found that Article 2 ECHR was engaged in that state agencies knew or ought to have known that Donna's life was at risk.

After hearing four days of evidence between 5 and 8 September 2022, HM Senior Coroner Ms Nadia Persaud made factual findings as follows:

- There should have been a formal assessment of Donna's capacity between July 2018 and December 2018. "*Donna was not an adult with no intellectual deficit and no underlying mental health disorder who was simply making unwise choices*".
- There was a failure to refer Donna for safeguarding assessment from July 2018. The view on Donna's capacity was not a reason to not refer the matter for safeguarding.
- There was a failure during July 2018 of the mental health and social care teams to ensure that Donna was receiving her prescribed medications for her physical and mental health.
- There was a failure on the part of the mental health team at ELFT to document the risk of harm to Donna from taking Martin's medication and a joint failure with London Borough of Newham to manage the risk. Immediate steps could have been taken to protect Donna.
- By 4 December 2018 it should have been clear to the social worker and the care coordinator that Martin was not a reliable carer, in light of the history of domestic abuse, the threat of eviction, the complete failure to provide Donna with her medication and the fact that the police and Anti Social Behaviour team believed that Martin was the main culprit in bringing drug users into the flat.
- The Coroner was unable to conclude on the balance of probabilities whether Martin had administered the medication to Donna but he was responsible for Donna having access to his medication in circumstances where this had been identified to be a risk.

Donna's mother and sister made the following statement: *"We have fought for over three years for answers about Donna's death. We believe that we were let down by the Metropolitan police who failed to conduct a full investigation into Donna's death and that their failure has*

denied us the full truth. We believe that Martin administered Donna the fatal dose of oxycodone and we are disappointed that the Coroner was unable to reach conclusions beyond finding that it was possible that he did so. We were shocked to hear the social worker and care coordinator attempting to justify the inhuman and degrading conditions that Donna was living in. We welcome the Coroner's conclusions that Martin's failure to care for Donna caused her death and that the failings by Donna's social worker at London Borough of Newham and care coordinator at ELFT also played their part".

The family's solicitor, Sophie Naftalin of Bhatt Murphy Solicitors said:

"This case sheds a light on the scandalous and neglectful conditions that Donna was living in all under the watch of her social worker at London Borough of Newham and her community mental health team at ELFT. We have heard evidence of how Donna as a vulnerable adult with learning disabilities was exploited by her husband and how professionals inappropriately relied on Donna's capacity as a reason for taking no safeguarding action. Despite a police investigation, a joint Serious Incident Review and a previous coroner's inquest - when the family were unrepresented - all failing to uncover the truth about Donna's care, the Senior Coroner has finally concluded that Donna died of neglect and that her complex needs were not properly managed by professionals. We can only hope that LBN and ELFT now publicly acknowledge their failings and commit to learning from the Coroner's findings."

ENDS

NOTES TO EDITORS

For further information, interview requests and to note your interest, please contact Sophie Naftalin at s.naftalin@bhattmurphy.co.uk

The family are represented by Sophie Naftalin of Bhatt Murphy and Sophy Miles of Doughty Street Chambers. The family were represented by Anna Morris of Garden Court Chambers in the judicial review of the first inquest.