Coroner ME Hassell
HM Senior Coroner
Inner North London

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: 1. [redacted] **Director of Adult Services** **London Borough of Hackney** **Hackney Town Hall** **Mare Street** **London E8 1EA** 2. **Dr Kevin Cleary** **Medical Director** **East London NHS Foundation Trust** **Trust Headquarters** **9 Alie Street** **London E1 8DE**
1	**CORONER** I am Sarah Bourke, assistant coroner, for the coroner area of Inner North 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.
3	**INVESTIGATION and INQUEST** On 17 January 2018, I commenced an investigation into the death of Dudley Vincent Brown (age 58). The investigation concluded at the end of the inquest on 15 May 2018. The conclusion of the inquest was a narrative conclusion which is set out in the circumstances of the death below. The medical cause of death was: 1a: multi organ failure 1b: septic shock secondary to Klebsiella bacteraemia 1c: community acquired pneumonia 2: chronic kidney disease, Wernicke-Korsakoff syndrome.
4	**CIRCUMSTANCES OF THE DEATH** Mr Brown had a number of health conditions including nephrotic syndrome, epilepsy, Wernike-Korsakov Syndrome and recurrent pulmonary embolism. He was in receipt of

	a care package to support him with personal care, meals and medication. Mr Brown's care package was withdrawn on 27 December 2017 after he threatened his carers with a metal bar. His Social Worker visited on 29 December 2017 and Mr Brown threatened her with a knife. The incident on 29 December 2017 was reported to police, who took no action. Mr Brown's social worker contacted his GP on 2 January 2018 and the GP referred Mr Brown for an urgent mental health assessment that evening. Mr Brown's case was passed to the Approved Mental Health Practitioner Service (AMHPS) on the morning of 3 January 2018. A warrant was applied for under Section 135 of the Mental Health Act. This was granted on 8 January 2018. AMPHS also collated information for a Police risk assessment form, which was completed on 8 January 2018. The form was referred to the Police Mental Health Liaison Officer along with the warrant later that day. An appointment was made for the assessment to take place at Mr Brown's home at 3 pm on 10 January 2018. When Police and the AMHPS attended the property, Mr Brown was found on the floor in a state of reduced consciousness. It is unclear how long he had been there. Paramedics were called and Mr Brown was taken to the Royal London Hospital where he was found to have multi-organ failure. Mr Brown did not respond to treatment and died at the hospital on the evening of 11 January 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. – (1) Following the incident on 29 December 2017, the incident was reported to police the same day. The social work team leader dealing with the case was of the view that the police were the best placed to initiate emergency procedures under the Mental Health Act. (2) Mr Brown's care package was withdrawn on 27 December 2017. No arrangements were put into place for Mr Brown's welfare to be checked in the period pending a mental health assessment. (3) The social work team leader dealing with this case was under the impression that referrals to the Approved Mental Health Practitioner Service (AMPHS) had to be made by a GP. (4) Mr Brown's referral to the AMHPS and subsequent assessment was delayed due to intervening weekends (including a 3 day bank holiday weekend). (5) Mr Brown's assessment by the AMHPS team was delayed due to the need for information regarding the nature of his property being required by the Metropolitan Police as part of their risk assessment.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 23 August 2018. 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. • [redacted] (sister of the deceased) I am also under a duty to send the Chief Coroner a copy of your response. 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 by the Chief Coroner.
9	**Sarah Bourke** **Assistant Coroner** **27 June 2018**