Coroner ME Hassell
HM Senior Coroner
Inner North London

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Sarah McClinton, Director of Adult Social Care, London Borough of Camden**
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 12 December 2017, Assistant Coroner Heather Williams commenced an investigation into the death of Jacob Sulaiman aged 65. The investigation concluded at the end of the inquest on 6 July 2018. In relation to how, when and where Mr Sulaiman came by his death, I found that: Mr Sulaiman sustained carbon monoxide poisoning after a fire started in his bedroom. He died at his home on 8 December 2017. I found that the medical cause of death was: 1a carbon monoxide poisoning 1b inhalation of products of combustion. My conclusion was that Mr Sulaiman's death was the result of an accident.
4	**CIRCUMSTANCES OF THE DEATH** Mr Sulaiman had a long history of mental health problems and alcohol dependence. He also had poor mobility and used walking aids. He was a smoker. He lived in Robert Morton House which is a retirement housing scheme and subscribed to the Careline Telecare Service ("Careline") which is a push button intercom service provided by Camden Council. Intercom calls connect to the manager of Robert Morton House during office hours. Out of hours, the service connects to "Wellbeing Lifeline" ("Wellbeing") who can ask response officers employed by Careline to visit the service user if required. Mr Sulaiman was well known to make repeated calls to emergency services and Careline during episodes of low mood, particularly if he was intoxicated. During these calls, he would sometimes express suicidal thoughts. In November 2017, he had 2 hospital admissions related to falls. On 21 November 2017 he was taken to St Mary's Hospital after contacting Careline stating that he wanted to die. He was discharged a few hours later. On 7 December 2017, he was again taken to St Mary's Hospital after repeatedly pressing his call alarm. He was aggressive to hospital staff and denied any thoughts of harming himself. He returned home on the morning of 8 December. During the course of the day, he made a number of Careline calls to the manager of Robert Morton House. In addition, he also contacted the Police. When police officers attended the property during the early evening of 8 December, Mr Sulaiman asked them what the point in living was and stated that he wanted to return to Holland. Mr Sulaiman told police officers that he

	did not want to be taken to hospital and instead went to bed. The police officers asked for the out of hours GP to contact them and left Mr Sulaiman in the property. At 9.50 pm Wellbeing contacted Careline response officers as they had received a call from Mr Sulaiman but he had not responded when they had tried to speak to him. Response Officers visited the flat and found Mr Sulaiman on the floor next to the bed. He was confused. He wanted his passport and asked to be taken to the airport. At 11.10 pm Wellbeing contacted response officers as Mr Sulaiman had contacted them to say that he was on the floor again. Response officers asked Wellbeing to call the London Ambulance Service due to Mr Sulaiman's responses and repeated falls. When paramedics attended at 12.10 am on 9 December Mr Sulaiman did not express any thoughts of harming himself and declined to be taken to hospital. He did however, ask if paramedics would take him to the airport so that he could return home. Mr Sulaiman made further contact with Wellbeing whilst paramedics were at the property. Paramedics updated Wellbeing during the course of that conversation. At 3.40 am Mr Sulaiman again activated his call alarm. He did not respond to Wellbeing. Response Officers attended at 4.06 am and found Mr Sulaiman asleep in bed. At 5.30 am Wellbeing contacted response officers to say that Mr Sulaiman had called from the entrance hall of Robert Morton House stating that he was waiting for a taxi to take him to the airport. Response officers advised that Wellbeing should suggest that Mr Sulaiman return to his flat and wait for the taxi there. At 7.44 am remote monitoring detected that the smoke and heat alarms in Mr Sulaiman's flat had been activated. The London Fire Brigade was called. Mr Sulaiman was found sitting in a chair in the living room. He was unresponsive. Resuscitation was attempted but Mr Sulaiman died at the scene. The fire investigator found that the fire was likely to have started when a naked flame was applied to combustible material in Mr Sulaiman's bedroom. It is unclear whether the fire had started as a result of an attempt to light a cigarette or whether Mr Sulaiman had deliberately started a fire as an attempt to get help to return to Holland from the Fire Service.
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) Response officers from Careline visited Mr Sulaiman twice during the night of 7/8 December 2017. It is not usual practice to leave a written record of those visits in the property. (2) In addition, Mr Sulaiman made a number of calls to Wellbeing which were referred to response officers for guidance. (3) Response officers only know about calls made to Wellbeing if the information is placed on the shared database. Response officers did not know the outcome of the paramedics' visit in the early hours of 8 December when they visited at 3.40 am. (4) Information regarding the nature and number of recent contacts with Wellbeing is not easily accessible to response officers dealing with an emergency call out. (5) From the evidence before me, it is evident that the services which visited Mr Sulaiman on the night of 7/8 December 2017 had an incomplete picture of the number of other services that Mr Sulaiman had contacted and his presentation at those times. In particular, had the London Ambulance Service had more information regarding the nature and number of calls that Mr Sulaiman had made to Careline, this may have had some bearing on the steps taken to assess his mental capacity and how Mr Sulaiman was managed.
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 15 October 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] (family) London Ambulance Service Origin Housing Limited 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**