Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
29 Wood Street,
Barnet EN5 4BE

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Metropolitan Police.
1	**CORONER** I am Mr Andrew Walker, H M Coroner and senior coroner, for the coroner area of Northern District of Greater 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 the 18th July 2019 I opened an investigation touching the death of Luke Anthony Flynn, aged 33 years old. I opened and inquest on the 19th June 2020. The inquest concluded on the 13th December 2021. The conclusion of the inquest was "Drug related", the medical case of death was 1a Multi Organ Failure and Hypoxic Ischaemic Brain Injury , 1b Acute Cocaine Toxicity.
4	**CIRCUMSTANCES OF THE DEATH** On the 17th of July 2019 Luke Anthony Flynn died in hospital despite treatment. Events began on the 13th of July 2019 towards the end of the afternoon when Mr Flynn started to behave erratically in Bilton Road. His behavior led to his being restrained by members of the public prior to police arriving. Mr Flynn was taken by ambulance to hospital where he was detained but not under arrest. Whilst in the care of clinicians, and at their request, Mr Flynn was handcuffed to the bed. The handcuffs were later removed. Mr Flynn was a patient suffering with a medical condition.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows. – 1. That there is no MET Police policy covering the use handcuffs when medical staff request their use with a patient in hospital for treatment with a medical condition rather than a mental health condition.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 Wednesday the 17th August 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 have sent a copy of my report to the Chief Coroner and to the following Interested Persons;- The Family. Northwick Park Hospital.
9	**22nd June 2022**