REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. London Borough of Bromley Council** **2. Oxleas NHS Foundation Trust** **3. Clarion Housing Group**
1	**CORONER** I am Jonathan Landau, assistant coroner for the coroner area of South 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 4 February 2022 an investigation was commenced into the death of Samuel Robert Pearson, aged 29. The investigation concluded at the end of the inquest on 12 October 2022. The narrative conclusion of the inquest was: A van crashed into Samuel's property on 20 June 2021. The accident caused a traumatic deterioration in his mental health. He was moved to accommodation that increased his anxiety, and no services were provided to mitigate that. On 6 July 2021, He took an overdose [redacted] and alcohol to help him sleep and he accidentally died as a result.
4	**CIRCUMSTANCES OF THE DEATH** Mr Pearson had complex mental and physical needs. He moved into his own accommodation in March 2021 following a period of good partnership working between relevant organisations. In June 2021, however, a van crashed into his home necessitating an emergency move to alternative accommodation. Mr Pearson struggled with the trauma of the accident, contributed to by the unsuitability of his temporary accommodation (a budget hotel).
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) Whilst there was good multi-agency working before Mr Pearson moved into his own accommodation, that was lacking when it became necessary to move him on an emergency basis despite the circumstances increasing his anxiety and vulnerability. Partnership working and sharing of information between the authorities may help mitigate risk in future cases of emergency decants. (2) In respect of Oxleas NHS Foundation Trust, a referral was made by Mr Pearson's GP

	to the ADAPT service but at the time there was a 2-3 backlog in screening referrals and the GP was not made aware of the capacity issues. A robust contingency plan would ensure that referrers are informed when services are not able to meet usual service expectations. I heard evidence of openness to remedy these matters, which is welcome, but plans were at a very early stage by the date of the inquest.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 5 January 2023. 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 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. 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	 **Jonathan Landau, HM Assistant Coroner** **10 November 2022**