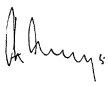
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted] Chief Executive Officer - Central North West London NHS Foundation Trust** **2 [redacted] Chief Medical Director - BLMK Integrated Care Board** **3 [redacted] Practice Manager – Red House Surgery**
1	**CORONER** I am Sean CUMMINGS, Assistant Coroner for the coroner area of Milton Keynes
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 01 July 2021 I commenced an investigation into the death of Odichukwumma Kelvin IGWEANI aged 24. The investigation concluded at the end of the inquest on 19 April 2023. The conclusion of the inquest was that he was lawfully killed.
4	**CIRCUMSTANCES OF THE DEATH** At the time of the incident Kelvin Igweani was living at [redacted]. Prior to the incident on the 26th June 2021 evidence shows Kelvin was suffering undiagnosed mental health problems, which were deteriorating over several months. Attempts by Kelvin's mother to secure mental health assistance for him were unsuccessful, as no formal assessments were made. His mental health then spiralled significantly in the four days proceeding the incident. On the morning of 26th June 2021, Kelvin became extremely violent, firstly trying to forcefully baptise his partner's children in the bath. His partner and her daughter were able to flee to knock on the neighbours flat ([redacted]) to seek assistance to call the police. His partner was then dragged back [redacted]. Kelvin then forcefully regained control of her two year old son and began to progress into holding him under water causing him to become unconscious. On a second successful attempt to flee to the neighbours flat ([redacted]), his partner and her daughter asked the neighbours to help save her son as Kelvin was trying to kill him. The [redacted] neighbour then went into [redacted] to try and save the two year old boy but was bludgeoned to death [redacted]. The neighbours [redacted] called the police and gave shelter to Kelvin's partner and her daughter. At this point, the first officer on scene attempted to gain entry after announcing she was police but was unsuccessful, so called for back-up assistance with method of entry equipment. The police arrived and forced entry into the flat. Kelvin was tasered ineffectively at the front door of the flat and retreated into the bedroom where he barricaded himself in with the two year old boy. Armed police forced entry into the bedroom after repeated unsuccessful attempted to secure the childs release and on hearing sounds of someone being beaten in the bedroom. At no point did Kelvin engage or respond to the police requests to cooperate. Kelvin sprung out of the wardrobe and lunged forward once the bedroom door had been taken down by police. The police discharged four shots and two of them hit Kelvin in the chest. Kelvin died from gunshot wounds. The evidence shows Kelvin suffered from a severe mental health episode leading to and at the time of the incident for

	which he was unable to access adequate mental health care and attention. No mental health input or care received, as there was no engagement with A&E, crisis team or any other mental health services.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: Out of hours and emergency mental health care for people who are not registered with an NHS GP in Milton Keynes may be obtained by attending the Emergency Department at the Milton Keynes University Hospital where mental health professionals are based. Through Kelvin's period of deteriorating mental health, which was obvious to those who knew him, his mother made repeated attempts to secure mental health assessment and care for him. She was not directed clearly by the professionals she did have contact with, to take him to the Emergency Department for assistance. There was a gap which Kelvin fell through and he did not receive either mental health assessment or care. It was not possible to say that the failure to receive assessment or care resulted in Kelvin attempting to take the lives of others and succeeding in taking the life of his male neighbour. It was clear that the lack of clear information and direction in regard to how to obtain that mental health assessment or care contributed to Kelvin not presenting for assessment which may possibly have averted the tragic events which unfolded on the 26th June 2021. This in turn raises the prospect that others, in similar predicaments may also be unable to obtain the care required.
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 October 10, 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 have sent a copy of my report to the Chief Coroner and to the following Interested Persons The family of Mr Igweani Thames Valley Police I have also sent it to the following who may find it useful or of interest: Midland Heart South Central Ambulance Service I am also 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. I may also send a copy of your response to any person who I believe may find it useful or of interest.

	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	**Dated: 16/08/2023**  **Sean CUMMINGS** **Assistant Coroner for** **Milton Keynes**