MR G IRVINE
SENIOR CORONER
East London Coroner's Court, Queens Road Walthamstow, E17 8QP

[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted]**, The Commissioner of Police of the Metropolis, Metropolitan Police Service** [redacted] [redacted] **Corporate Director Adult Social Care and Quality Standards, London Borough of Waltham Forest** [redacted], Principal Adults Lawyer **3.** [redacted]**, Director for Care and Support, Outlook Care Ltd,** [redacted] **4. The Care Quality Commission** [redacted]
1	**CORONER** I am Graeme Irvine, senior coroner, for the coroner area of East 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 24th March 2023, this court commenced an investigation into the death of Sydney Piper, aged 69 years. The investigation concluded at the end of the inquest on 14th

	March 2024. The court returned a narrative conclusion. "*Sydney Alex Piper was discovered deceased in a tent on 24th March 2023 in Epping Forest near to Sky Peals Road, IG8. His death was caused by morphine toxicity.* *Mr Piper was a vulnerable adult who was diagnosed with schizophrenic illness and a cognitive deficit. Mr Piper was cared for in supported accommodation where lawful restrictions were placed on his liberty. Mr Piper was to receive constant 1:1 supervision from a support worker when he left his home.* *On 23rd February 2023 he left home to attend a medical appointment accompanied by a support worker. Due to a significant and sustained lapse in supervision Mr Piper left his medical appointment unaccompanied. Mr Piper travelled to a nearby park and then to a nearby residential street, after that there was no trace of the deceased until the discovery of his death a month later.* *It has not been possible to determine how Mr Piper came to have been administered morphine or how he came to be at the site he was located."* Mr Smith's medical cause of death was determined as; 1a Morphine Toxicity
4	**CIRCUMSTANCES OF THE DEATH** Sydney Piper was a 69 yr. old man who had spent much of his life in supported accommodation due to mental health problems. On 23rd February he was escorted by support staff to an appointment at a mental health clinic to receive a depot medication injection. In all excursions outside of his home Mr Piper was to be always subject to supervision by a support worker. Upon arrival at the clinic, Mr Piper was ignored by his carer who sat in an area away from Mr Piper and looked at her phone. For much of this period, Mr Piper was out of the direct line of sight of his carer. Mr Piper left the clinic on three occasions, the final time (11.14) he did not return. Mr Piper's absence was not noticed until 11.51. Procedures indicated by Mr Piper's care provider were not effectively followed and a delay of 1 hour and 23 minutes was recorded between the discovery of his disappearance and a call being made to 999. A missing persons investigation was commenced but it was not until 24th March 2023 that Mr Piper was discovered in a tent on the outskirts of Epping Forest. Mr Piper had been dead for some time. Although no drug paraphernalia was found near to the deceased his death was later determined to have been caused by morphine toxicity.
5	**<u>CORONER'S CONCERNS</u>** 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. The support worker who accompanied Mr Piper on the day of his disappearance claimed that she did not constantly supervise Mr Piper as alternatively; she did not wish to crowd him, she was allergic to cigarette smoke, and finally that she

	needed to rest her legs. The witness accepted that she had neither read Mr Piper's support plan, nor the relevant policies and procedures relevant to her duties that day. I am concerned that there is no clear evidence before me that the risk of a similar incident of inadequate supervision of a vulnerable person has been effectively mitigated. 2. Mr Piper's death was the latest in a series of deaths investigated by this court in which homeless persons have died in tents and encampments in wooded areas along the A406 and the periphery of Epping Forest due to high risk behaviours including, but not limited to, crush injuries, fire, third party assaults and drug misuse. The monitoring and policing of such encampments is, in the view of the court, lacking which increases the risk of fatal harm.
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 **10th May 2024** 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 Piper and to the local Director of Public Health who may find it useful or of interest. 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 other 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.
9	**[DATE] 15/03/2024** **[SIGNED BY CORONER]**