MR G IRVINE
SENIOR CORONER
EAST LONDON
Walthamstow 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], **North East London Foundation Trust (NELFT), CEME Centre, March Way, Rainham, Essex, RM13 8GQ Email:** [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 27th October 2023, this court commenced an investigation into the death of Olayemi Oluwarotimi Kodjo Kehinde aged 34 years. The investigation concluded at the end of the inquest on 23rd April 2024. The court returned a short form conclusion of "Road Traffic Collision"; Mr Kehinde's medical cause of death was determined as; 1.a. Haemothorax 1.b. Blunt Force Trauma (Road Traffic Collision)
4	**CIRCUMSTANCES OF THE DEATH**

	Olayemi Oluwarotimi Kodjo Kehinde was a 34-year-old man with a history of schizophrenic illness. Mr Kehinde walked into fast-moving traffic on a busy dual carriageway on 26th October 2023. Mr Kehinde was struck by a van and later that day died from his injuries.
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. In July 2011, Mr Kehinde was an inpatient subject to an order under S.3 Mental Health Act 1983. On 2nd July 2011, Mr Kehinde was granted escorted S.17 leave to return home to collect belongings. Mr Kehinde left the ward in the company of a mental health nurse and they both travelled to a tattoo parlour. Mr Kehinde's face was tattooed with a large permanent tattoo. No action was taken by the nurse to prevent this act occurring. The incident was not investigated as a serious incident by the Trust. Whereas the court does not suggest that a facial tattoo constitutes a factor that would likely cause a future death, concerns arise regarding; • The ability of staff authorised to supervise S.17 leave at identifying serious incidents that require meaningful intervention. • The ability of the Trust to identify matters that require a full governance investigation.
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 **19th June 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; the family of Mr Kehinde. I have also sent it to 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] 24 April 2024 [SIGNED BY CORONER]**