Regulation 28: Prevention of Future Deaths report

Mohammed AKRAMUZZAMAN (died 08.12.23)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Chief Constable** **British Transport Police** **BTP Headquarters** **25 Camden Road** **London NW1 9LN**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 5 January 2024, one of my assistant coroners, Ian Potter, commenced an investigation into the death of Mohammed Akramuzzaman, aged 39 years. The investigation concluded at the end of the inquest on 3 June 2024. I made a determination at inquest that Mr Akramuzzaman died from a combination of an alcohol related condition (not acute intoxication) and hypothermia. He was found beside Euston Station in cardiac arrest at approximately 7am on 8 December 2023. He had been out on the street all night. His medical cause of death was: 1a) alcohol related ketoacidosis 2 hypothermia.

4	**CIRCUMSTANCES OF THE DEATH** Concern had been raised by a member of the public the previous evening and British Transport Police did attend, but Mr Akramuzzaman refused medical treatment and BTP did not return. Medical care and a warmer environment at this point would have saved his life.
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 will occur unless action is taken. In the circumstances, it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. There were some elements of good practice about which I heard at inquest. BTP officers attended Mr Akramuzzaman very quickly after a concern was raised by a member of the public, and they asked him if he was alright and if he wanted medical treatment. They also told me that sometimes they take people to hospital in a wheelchair (UCH is just over the road from the station) rather than wait for an ambulance. That seems proactive and practical. 1. However, the officers left Mr Akramuzzaman after he had simply nodded that he was alright and shaken his head that he did not want medical treatment. They never actually heard him speak. They did not attempt to stand him up to see if he was able to support himself. I appreciate that if Mr Akramuzzaman had mental capacity then he could not be forced to go to hospital, but it is difficult to see how he could have been assessed properly following just a nod and a shake of the head. 2. The three station officers (one PC and two PCSOs) who attended Mr Akramuzzaman told me that they had placed great reliance on hearing a BTP response officer (one of three who had arrived just moments before the station officers) give an opinion over the radio that Mr Akramuzzaman was "coming round" after having taken drugs or alcohol. However, the station officers were themselves very experienced, and should have formed their own view. 3. The officers also eventually accepted at inquest that it was impossible to decide so quickly that this was a drug comedown.

4. It must have been a very cold night (it was minus 4ºC when he was found in the morning), but nobody went back to check on Mr Akramuzzaman later.

   I appreciate that a decision had to be made about what action to take there and then. But when I asked, BTP witnesses agreed that it would have been an easy matter for an officer on patrol later to check on a person in that situation.

   No consideration was given to that by either of the PCSOs, by the PC, or by the sergeant who then took the decision to cancel the ambulance called earlier.

5. I was told that the BTP officers had reflected a lot about this incident in the time since, and had learnt a lot. However, when giving their evidence they struck me as defensive, and they were unable to point to any specific learning or any changes in their procedures following Mr Akramuzzaman's death.

   Whilst I readily accepted that the officers had talked about Mr Akramuzzaman since his death, I did not gain the impression of a culture of learning.

   The sergeant told me that before the inquest, he had not known about the existence of ketoacidosis. The officers reminded me that they are not healthcare professionals. However, as I explained in court, I was not suggesting that they should have a particular understanding of ketoacidosis.

   Mr Akramuzzaman could have been suffering from any number of medical conditions. He could have sustained a subtle head injury. He could have had diabetes (which, as it happens, can also result in ketoacidosis). He could have had epilepsy. The list goes on.

   Mr Akramuzzaman did not need the BTP officers to be doctors in order to survive this episode, but he was probably already confused when officers dealt with him, and he needed them to make an appropriate assessment and to take appropriate action as BTP officers.

   The sergeant told me that he thought learning should be undertaken by BTP at an organisational level.

6 **ACTION SHOULD BE TAKEN**

In my opinion, action should be taken to prevent future deaths and I believe that you 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 31 July 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 following. • [redacted], cousin of Mohammed Akramuzzaman • HHJ Alexia Durran, the Chief Coroner of England & Wales 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. She may send a copy of this report to any person who she 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** **SIGNED BY SENIOR CORONER** 05.06.24 *ME Hassell*