Regulation 28: Prevention of Future Deaths report

Joanita Nalubowa (died 15.01.2021)

	THIS REPORT IS BEING SENT TO: **Ministry of Housing, Communities and Local Government** **2 Marsham Street** **London** **SW1P 4DF** **United Kingdom**
1	**CORONER** I am: Harry Lambert Assistant Coroner Inner North London Bow Coroner's Court Bow Road London E3 3AA
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 February 2021 the Senior Coroner, Mary Hassell, commenced an investigation into the death of Joanita Nalubowa, born in Uganda on 27th May 1990. The investigation concluded at the end of the inquest on 5 August 2024. On 25th December 2020 Ms Nalubowa suspended herself with a ligature, whilst an inpatient at the St Pancras Hospital in King's Cross. She was successfully resuscitated but sustained an hypoxic brain injury from which she subsequently died. The jury returned a conclusion of Misadventure, and found as follows in Box 3: *Death by hanging* [redacted]

	The medical cause of death was 1a Hypoxic ischaemic encephalopathy 1b Asphyxiation by hanging 1c Severe major depression
4	**CIRCUMSTANCES OF THE DEATH** (1) Immediately prior to her detention the Deceased had been living in Stockton in the North of England (near Middlesbrough). (2) However she was now divorced with few ties to that area. (3) Moreover, importantly, concerns had been raised that the ex-partner in question was abusive. (4) The Deceased's family and support network was in London and not Stockton. (5) Returning to Stockton was a source of great anxiety for the Deceased. She commented that she would "rather die than return to Middlesbrough [sic]". (6) It was clear to treating clinicians that securing the right accommodation was paramount to her mental health prognosis and to her future more generally. (7) It was clear to treating clinicians that surrounding the Deceased with a positive supportive network of family was crucial in maintaining mental health. (8) Despite all of the above, the existing framework/rules were such that all London boroughs, correctly applying the relevant criteria, rejected the Deceased's applications for accommodation in London. (9) The witness evidence was clear that there was no "discretion" and that London Boroughs and treating clinicians alike were powerless. The Deceased was therefore discharged to Stockton, against her wishes, against medical advice, away from her support network, and to an area where she would have to at best face her demons and at worst be in physical danger.

	(10) Shortly after being told she was being discharged to Stockton, the Deceased suspended herself using a ligature.
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. Please see Box 4, above. The evidence at the Inquest was that this situation is not uncommon, with those detained under the MHA not infrequently having social circumstances such that their historical place of residency is, for whatever reason, deeply inappropriate (or even dangerous). It should be noted that section 117 Mental Health Act 1983 did **not** apply. I am concerned that the rigidity and lack of flexibility in the criteria, coupled with the evidence this is a not uncommon phenomenon, gives rise to a risk of future deaths in cases which do not meet the threshold for aftercare under s.117. Consideration should be given to giving decision makers greater latitude / discretion or the power to apply common sense, in circumstances where (a) it is foreseeable that rigid adherence to criteria will lead to personal injury (including psychiatric injury) and/or serious emotional harm (b) there is an obvious alternative solution, such as accommodation near family.
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 8 October 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] • Minister of State at the Ministry of Housing, Communities and Local Government • Stockon on Tees Borough Council • Camden and Islington Trust ("CANDI") • 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. 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** **SIGNED BY ASSISTANT CORONER** **13.08.24**