REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Secretary of State for Justice, Ministry of Justice** **2. [redacted], Commissioner of the Metropolitan Police**
1	**CORONER** I am Sarah Bourke, HM Assistant Coroner, for the coroner area of Inner North 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.
3	**INVESTIGATION and INQUEST** On 4 October 2023, Assistant Coroner Smith commenced an investigation into the death of Ronald Bainborough aged 52 years. The investigation concluded at the end of the inquest on 15 July 2024. The jury made a natural causes conclusion supported by a narrative, which I attach. I drafted this report in early October 2024. However, it was not issued at that time owing to an IT error.
4	**CIRCUMSTANCES OF THE DEATH** Mr Bainborough lived in supported living accommodation. He had a history of schizophrenia and substance misuse but had been discharged from mental health services in 2022 due to poor engagement. Mr Bainborough was not taking anti-psychotic medication and did not engage with his GP. Mr Bainborough's mental health problems contributed to him being visibly underweight. Attempts were made to assess Mr Bainborough's physical and mental health, but Mr Bainborough refused to engage. Following a failed attempt to informally assess Mr Bainborough under the Mental Health Act on 5 June 2023, it was decided to apply for a warrant under Section 135(1) Mental Health Act so that Mr Bainborough could be detained to enable an assessment to take place. There were significant delays in applying for a warrant for reasons specific to the circumstances of this case. An application

	for a warrant was submitted to the Magistrates Court on 18 August 2023 and the warrant was granted at a hearing on 23 August. Once a warrant was issued, an appointment was made for police officers to execute the warrant on 7 September 2023. Before the warrant could be executed, Mr Bainborough was admitted to hospital on 29 August 2023 suffering from malnutrition. He had a BMI of around 13. He was detained under Section 2 of the Mental Health Act. The plan was for him to receive physical and mental health treatment in an acute hospital setting until he was physically well enough to be transferred to a psychiatric unit. Mr Bainborough died on 11 September 2023. The medical cause of his death was: 1a) community acquired pneumonia and malnutrition; 1b) anorexia and chronic schizophrenia; 2) chronic obstructive pulmonary disease. The Jury found that the delay in applying for a warrant may have affected the outcome for Mr Bainborough.
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) During the Inquest, evidence was heard from 2 consultant psychiatrists and an Approved Mental Health Act Professional (AMHP) regarding the timescales for applying for and executing s135(1) warrants. All of them had concerns about the time taken for a warrant to be issued and executed (2) The warrant application was submitted to the Magistrates Court on 18 August 2023, the hearing took place on 23 August and it was intended that the warrant would be executed on 7 September 2023. This was a timescale of 20 days. The jury was told that this timescale was typical of the time taken to apply for and execute a s135(1) warrant in the experience of the professionals giving evidence at the Inquest. (3) Applications for a warrant are heard at Westminster and Uxbridge Magistrates Courts which consider applications from all 32 London Boroughs. There are a limited number of video hearing slots, so AMPH teams may have to wait several days for a hearing. (4) Once a warrant has been issued, an appointment then needs to be arranged for police officers to execute the warrant. The evidence before the court was that it would generally take in the region of 10 days for an appointment to be scheduled. (5) There is no official fast track procedure. Consequently, there is a risk of harm to the individual and others during the time taken for a warrant to be granted and executed.

	(6) As individuals have been identified as requiring assessment under the Mental Health Act, the risk of potential harm is recognised. In the absence of treatment, there is an ongoing risk that individuals will harm themselves or others before the warrant can be executed. This includes a 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 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 15 April 2025. 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 (a) Family of Ronald Bainborough (b) London Borough of Haringey (c) Barnet, Enfield and Haringey NHS Foundation Trust (d) East London NHS Foundation Trust (e) Homerton Healthcare NHS Foundation Trust (f) London Ambulance Service NHS Foundation Trust (g) St Mungo's I am also under a duty to send the Chief Coroner a copy of your response. 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 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	**18 February 2025** **Sarah Bourke**