Prevention of Future Deaths Report - Paul Christopher REEVES
(date of death: 9 April 2024)

	Regulation 28 Report to Prevent Future Deaths
	THIS REPORT IS BEING SENT TO: Chief Executive The Riverside Group Limited 2 Estuary Boulevard Estuary Commerce Park Liverpool L24 8RF
1	**CORONER** I am Ian Potter, assistant coroner for 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 23 April 2024, an investigation was commenced into the death of Paul Christopher REEVES, aged 29 years at the time of his death. The investigation concluded at the end of an inquest heard by me on, 5-6 December 2024, 6 March 2025, and 15 April 2025. The conclusion of the inquest was 'drug related'. The medical cause of death was: 1a cardiac arrest 1b hypoxia and drug induced arrythmia 1c aspiration pneumonia and acute respiratory distress syndrome 1d harmful use of drugs and other psychoactive substances (clinical diagnosis) II schizophrenia, obesity
4	**CIRCUMSTANCES OF DEATH** On 25 March 2024, Paul Reeves returned to his supported accommodation (Maygrove Road, London) for a period of leave from the mental health unit where he had been detained. Staff at his supported accommodation missed an opportunity to report their concerns about Mr Reeves during a telephone call from mental health staff on 27 March 2024. This did not make a material contribution to Mr Reeves' subsequent death.

	Having used unknown drugs / psychoactive substances in the early morning of 28 March 2024, Mr Reeves crawled out of the supported accommodation building and into the carriageway of the road. While out of the building he ingested mud, some of which he aspirated. Mr Reeves was conveyed to the Royal Free Hospital, where he was found to be critically unwell. His ingestion / aspiration of mud was a significant factor. On 9 April 2024, Mr Reeves became agitated and his clinical situation deteriorated to the extent that he required re-intubation. During re-intubation, he suffered a cardiac arrest. Despite successful re-intubation and extensive attempts at resuscitation, Mr Reeves' death was verified in hospital that afternoon.
5	**CORONER'S CONCERNS** During the course of my investigation and 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. Maygrove Road, the supported accommodation, is not a care home and there is no expectation that staff at the accommodation will administer or supervise medication. Despite this, staff at the accommodation documented that they had collected Mr Reeves' medication 'for daily supervision'. Staff were aware that it was an expectation, from the mental health unit, that the accommodation staff should supervise Mr Reeves' compliance with his medication. There is no suggestion that the accommodation provider contacted the mental health unit to advise that this was something that they were unable to facilitate. The concerns here are twofold. First, there appeared to be a lack of awareness from staff at Maygrove Road about the nature and extent of what they could/should do to support residents. Second, there was a lack of communication with the treating mental health team. 2. During a welfare check on Mr Reeves on the morning of 26 March 2024, it was noted that Mr Reeves was 'agitated' and that 'there were broken glasses and pulled electrical panel in his flat'. It was also noted that Mr Reeves 'didn't know what had happened'. The mental health unit contacted staff at Maygrove Road on 27 March 2024 and it was accepted in evidence that the concerns about Mr Reeves' behaviour and the damage caused to his flat were not mentioned to the mental health staff. In the circumstances, these matters not having been raised with the mental health staff deprived the mental health team of an opportunity to assess Mr Reeves' mental state and leave status, and to consider whether or not he should have remained on leave. The manager at Maygrove Road told me in evidence that they would not

	expect staff to raise these matters with the mental health team; something which I found to be 'irrational'. While I found that there was insufficient evidence to suggest that this would have altered the outcome for Mr Reeves, it raises serious concerns about communication that would enable mental health professionals properly to assess the needs and status of patients in the community, particularly given that the accommodation 'generally supports residents with mental health needs'. 3. Although concerns regarding Mr Reeves' presentation (para 2 above) were not raised during the telephone call from mental health staff, the manager of Maygrove Road did send an email to Mr Reeves' care co-ordinator. That email raised health and safety concerns relating to the damage caused by Mr Reeves to his room/flat. However, it did contain phrases such as, 'he is not doing well' and he appears 'very unwell'. I found that an email (essentially headed as a health and safety matter) essentially raised concerns about escalation and communication of a deteriorating patient. 4. In the early morning of 28 March 2024 (approximately 07:13), the CCTV footage showed Mr Reeves crawling out of the front entrance to Maygrove Road, initially into the bin area and, a few minutes later, into the road. A support worker from Maygrove Road can be observed walking towards Mr Reeves. However, from the CCTV footage, the support worker appears to make limited attempts, if any, to engage Mr Reeves or block his path into the carriageway of the road. I heard evidence that staff members would not be permitted to restrain Mr Reeves; however, the CCTV footage raises concerns that staff may lack the knowledge, skills or training in handling or attempting de-escalate a situation such as this. For the avoidance of doubt, there was no evidence that an improved response would have altered the outcome for Mr Reeves, but that does not diminish the future risks to others.
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 7 July 2025. I, the coroner, may extend the period. Your response must contain details of the 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 Reeves; • North London NHS Foundation Trust; and • Royal Free London NHS Foundation Trust. 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 form 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 publication of your response by the Chief Coroner.
9	**Ian Potter** HM Assistant Coroner, Inner North London 12 May 2025