REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Mr Paul Rogers, Assistant Coroner, for the coroner area of Inner West London
2.	**DATE OF REPORT** **24th April 2026**
3.	**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.	**THIS REPORT IS BEING SENT TO** 1.NHS England 2.OneLondon Board 3.London Ambulance Service NHS Trust 4.South London and Maudsley NHS Foundation Trust 5.The College of Policing 6. The Commissioner of the Metropolitan Police You are under a duty to respond to this report within 56 days of the date of this report, namely by [date]. I, the coroner, may extend the period if an appropriate application is made.
4.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.

	The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
5.	**SUMMARY OF CORONER'S CONCERN** **I have two main areas of concern:** **(1) The understanding about and application of sections 135 and 136 of the Mental Health Act 1980 by police officers** **(2) The integration and accessibility of patient health care records which contain important patient safety information about risks they may present to themselves and others, and more generally contain information that will assist a treating clinician with little or no knowledge of the patient to make properly informed decisions about treatment or risk management.**
6.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
7.	**INVESTIGATION AND INQUEST** On 7th September 2023, an inquest into the death of Edward Muwanga was opened who died on 7th August 2023 aged 36 years. The inquest was held and concluded with a jury between 19th – 27th January 2026 and 3-4 March 2026 **Findings of the Jury:** **The medical cause of death was 1(a) Multiple trauma** **How, when and where** On August 7th 2023, Edward Muwanga entered Queensway London Underground Station. He descended on to the trackway, where he was struck by a train, which resulted in his death. Based on the evidence provided, we find that the following matters were probably causative of his death: a) The actions of Eddie when entering the track; and b) There was a delay by central line controllers in notifying the driver to slow down and/or stop the

train.

There are a number of failings or omissions that we wish to record:

1) The Care Co-ordinator was made aware that a warrant to section Eddie was granted on 2nd August 2023. This information was not provided to Eddie's assisted living facility.

2) As a consequence, when Police and Ambulance crews attended Eddie's assisted living facility on 6th August 2023, (following reports of him walking into oncoming traffic), they were not made aware of the warrant having been granted. Similarly, the 111 NHS doctor who discharged Eddie from the Ambulance's care made their decision to do so without this crucial information.

3) The LAS attendee provided limited information and details regarding Eddie's condition to the NHS 111 doctor. Notably, the record of their call indicates that the 111 NHS doctor inferred from his comments that Eddie would be watched closely by employees in his assisted living facility in the hours that would follow. This led to them agreeing to the discharge.

4) The LAS NHS Trust made a series of admissions about the NHS 111 doctor as follows:

a) There was a failure to communicate with Eddie directly on the 6th August 2023 during the course of his assessment; and

b) There was a failure to communicate with Eddie's community mental health team.

These acknowledged shortcomings did not affect the outcome.

5) The Police's visit to Eddie's assisted living facility was cursory in nature. They left after spending no more than ten minutes discussing his prior actions,

	his condition and the plans for his oncoming care and wellbeing. The haste with which they departed - having failed to take reasonable steps to check the status of the warrant - is a noteworthy omission, and indicative of a cavalier attitude to someone in a mental health crisis. A more detailed, measured and thoughtful assessment of Eddie's situation was warranted. 6) The Police officers who attended Eddie on 6th August 2023 did not properly understand their powers under Section 136 MHA 1983. **Conclusion** Accidental Death: Caused by Eddie's entry on to the trackway. We do not believe he intended to die.
8.	**CIRCUMSTANCES OF DEATH** Edward Muwanga (Eddie) had a diagnosis of paranoid schizophrenia since 2010 which encompassed auditory hallucinations including commands from God. He suffered from times when he determined not to take his prescribed medication which led to a deterioration in his self care and neglect of his hygiene. He was being treated by the community mental health team from South London and Maudsley NHS Trust. In July matters had deteriorated to the point his treating psychiatric team determined he should be assessed at a hospital. Eddie refused to go and so steps were taken to obtain a warrant under section 135 MHA 1980 to take him under compulsion. A warrant was granted on 2nd August 2023 but was not executed. Eddie's accommodation at 2 Verdant Lane were aware of the application to obtain the warrant but on 6th August were not aware it had been granted. Eddie was not detained at 2 Verdant Lane which was supported living accommodation and not locked or restricted in any way. On 6th August 2023 Eddie left his accommodation and entered the road outside. Staff were concerned for him and dialled 999. Police attended on the 999 call but Eddie had returned to the shared lounge at his accommodation. Police did not speak to him. Officers believed wrongly that they could not use their powers under section 136 MHA 1980 because Eddie was in the lounge at his home, even though this was a shared lounge with other residents. The London Ambulance Service were also spoken to by both police and staff at the accommodation. Police left without speaking to or assessing Eddie as they felt matters were better addressed by the ambulance team. They also made no inquiries as to the existence of the section 135 MHA 1980 warrant, when information could have been obtained that addressed that. The ambulance crew assessed Eddi and called an NHS 111 doctor for approval to leave Eddie on site as they considered it was safe to do so. The

	NHS 111 doctor agreed he could remain on site, but had not accessed all of his available medical notes. At 2226 on 6th August 2026 Eddie left his accommodation unnoticed, and eventually arrived naked at Queensway underground station at about 0655. He entered the station, descended to the platform where he climbed down onto the running tracks as a train was entering the station. He was struck despite the train driver applying emergency braking and suffered multiple injuries from which he died at the scene. The jury found that there was a delay by central line controllers in alerting the driver of the train to Eddie's presence which probably contributed to the death. In addition the jury found and recorded other failings and omissions set out above.
9.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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) A failure by the three police officers attending to understand that their powers under section 136 MHA 1980 applied to persons in a communal space within private accommodation and thereafter a failure to make a more detailed and measured assessment of the Eddie's situation (2) A lack of awareness by the two less experienced officers about the process under section 135 MHA 1980, and a lack of inquiry by the more experienced officer as to the existence of such a warrant, together with a concern that it was not clear from the evidence where information about the warrant could be obtained by officers. (3) The sharing and visibility of important health care records between medical agencies, (held on multiple platforms by multiple health care agencies) in particular here between the treating Trust (SLAM) and NHS 111, and between the Ambulance Service (not NHS 111) and the treating Trust (SLAM). [redacted] from London Ambulance Service NHS Trust writes to me in her PFD statement that "it is recognised that there remain challenges with the visibility of information from healthcare settings across London. While advances have been made, the visibility of pertinent information depends on technological developments and the coordination of a complex healthcare system." In her written evidence to me dated 19th March 2026 [redacted] Chief Medical Officer of LAS NHS Trust, writes that "..there is currently no single, comprehensive system that provides universal access to all patient records across NHS organisations. Access is influenced by information governance requirements, system interoperability, commissioning arrangements, and the extent to which partner organisations upload information to shared platforms." Whilst this fragmented situation persists with a multiplicity of systems, platforms, screens, and process in which important patient safety information is

	embedded the risk such information is not identified or communicated to practitioners making healthcare decisions remains and as such gives rise to a risk of death due to decisions being made on incomplete information where more complete information exists. In relation points (1) and (2) I believe the Commissioner of Police for the Metropolis, and the College of Policing are responsible for how officers are trained and educated, and which are the relevant practices and processes for officers to adopt when dealing with persons in mental health crisis in the community as part of their core policing duties. The Commissioner is also responsible for ensuring that processes exist whereby officers can locate and identify relevant information to the exercise of the duties such as the existence of the section 135 warrant in this matter. In relation to point 3 I believe that NHS England, London Ambulance Service NHS Trust, South London and Maudsley NHS Foundation Trust and OneLondon Board all have a part to play in the delivery of integrated and accessible care records and as such can take action to prevent future deaths.
10.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: *[please do not use individual's names, but instead roles/titles]* 1.Eddie's Family 2.NHS England 3.South London and Maudlsey NHS Foundation Trust 4. London Ambulance Service NHS Trust 5. The OneLondon Board 6. The College of Policing 7. The Commissioner of Police for the Metropolis I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.

	SIGNATURE  **Mr Paul Rogers** **HM Assistant Coroner for Inner West London**