Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
29 Wood Street,
Barnet EN5 4BE

Telephone 0208 447 7680
Fax 0208 447 7689

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Department of Health Richmond House 79 Whitehall London SW1A 2NS
1	**CORONER** I am Andrew Walker, senior coroner, for the coroner area of Northern District of Greater 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 the 6th Day of March 2013 I opened an investigation touching the death of Dean Emrode Elie , 33 years old. The inquest concluded on the 16th December 2014. The conclusion of the inquest was "Open", the medical case of death was 1a Unascertained due to decomposition in an individual with schizophrenia.
4	**CIRCUMSTANCES OF THE DEATH** On the twenty-seventh of February 2013 Dean Emrode Elie was found at his home having died in his sleep. Mr Elie suffered with paranoid schizophrenia and type 2 diabetes mellitus, and lived in a 1 bedroom flat. Mr Elie had capacity to make decisions about his treatment. It was likely that Mr Elie was controlling his diabetes by self administering his insulin and checking his blood sugar as had he not done so it is likely that he would have become very unwell. Mr Elie missed a number of appointments made by his GP for medication review, diabetic clinic review and for blood test between January 2012, when his last diabetic review took place and his death on the 27th February 2013. There were concerns raised at the inquest that there did not appear to be any way of ensuring that Mr Elie attended reviews arranged by his GP.

	At the inquest evidence was heard that taking into account Mr Elie 's circumstances, in particular that he had capacity, detention under the Mental Health Act, even if that were possible, could not be used to provide treatment for a medical condition.
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. – Consideration of further legislation to deal with this point.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 Monday 30th February 2015. 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;- Representatives of the family and the Mental Health 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 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 by the Chief Coroner.
9	**6 January 2015**