Regulation 28: Prevention of Future Deaths report

Chadrack Mbala MULO (died 18.10.16)

	THIS REPORT IS BEING SENT TO: **1. The Right Honourable Edward Timpson MP** **Minister of State for** **Vulnerable Children and Families** **Department for Education** **Piccadilly Gate** **Store Street** **Manchester** **M1 2WD**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
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 26 October 2016, one of my assistant coroners, William Dolman, commenced an investigation into the death of Chadrack Mbala Mulo, aged 4 years. The investigation concluded at the end of the inquest on 10 April 2017. At inquest, I made a determination as follows. Chadrack had learning difficulties and, when his mother died unexpectedly at home on 1 or 2 October 2016, he did not know how to call for help or feed himself properly. He died a fortnight later of dehydration and starvation. He was then found within approximately 48 hours.

	His medical cause of death was: 1a dehydration and acute protein-energy malnutrition 2 autism spectrum disorder (ASD)
4	**CIRCUMSTANCES OF THE DEATH** Chadrack's mother suffered a sudden death in epilepsy, probably on 1 or 2 October 2016. Chadrack was not seen in school after 30 September 2016. The staff at Morningside Primary School were concerned and rang his mother on several occasions. They also visited the home twice, but could not gain access to the block of flats where Chadrack and his mother lived. The likelihood is that Chadrack lived alone in the family home for over a fortnight after his mother's death. He was found a couple of days after his own death, with his arms around her body. She was by then very decomposed.
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. 1. The school had a telephone number for Chadrack's mother, but not for any other family member or friend. Now, they insist that for every child in the school they have the telephone number of three different adults. 2. If a child unexpectedly fails to attend and no relevant adult can be contacted via phone, staff at the school do not now wait three to five days as they did then, but instead immediately send a member of staff to the family home. They now make a distinction between an attendance issue that may warrant a penalty (not the case for Chadrack because he was under the age of five years) and a potential welfare issue. 3. If there is no answer at the family home when staff members attend, they now immediately contact the police, who in most cases are likely to force entry.

	This protocol seems very sensible, but is clearly driven by the appalling tragedy of Chadrack's death. It seems unlikely that other schools in Hackney, elsewhere in London, or indeed in the rest of England & Wales, have such a system in place.
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 19 June 2017. 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. • HHJ Mark Lucraft QC, the Chief Coroner of England & Wales • City & Hackney Safeguarding Children Board • [redacted], headteacher, Morningside Primary School • [redacted], Chadrack's father • [redacted], Chadrack's auntie 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 12.04.17