REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Rt Hon Justin Tomlinson MP, Minister of State for Disabled People, Health and Work, Caxton House, Tothill Street, London, SW1H 9NA**
1	**CORONER** I am Dr Richard Brittain, 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** Alexander Boamah died on 26 January 2019, aged 54. The inquest into his death concluded on 3 July 2019. The cause of Mr Boamah's death was unascertained and I reached an open conclusion.
4	**CIRCUMSTANCES OF THE DEATH** Mr Boamah had a history of heroin and crack cocaine misuse. He was under the care of Camden and Islington NHS Foundation Trust for the treatment of this condition. In late 2018 Mr Boamah was granted Personal Independence Payment by a Tribunal; this included a payment of approximately £18,000. Concerns were raised amongst his treating team that receipt of such a large sum of money could place Mr Boamah at risk, given the potential for unrestrained access to illicit drugs. Attempts were made to assess Mr Boamah's capacity to manage his finances but he did not attend the planned consultations. I heard evidence from Mr Boamah's treating psychiatrist that his service had no recourse to express concerns or intervene to address the risks that receipt of this money posed. Following receipt of this money Mr Boamah began to disengage from his addiction treatment and increased his reported use of illicit substances. Mr Boamah was found deceased in his own residence on 26 January 2019. Post-mortem toxicology was not able to establish the concentration of illicit substances in his blood. However, liver sampling was able to demonstrate the presence of both cocaine metabolites and morphine.
5	**<u>CORONER'S CONCERNS</u>** 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) There is a real risk that future deaths will occur where large sums of money are received by individuals who are then placed at risk through unrestrained access to illicit substances. Whilst it is recognised that individuals should not be deprived of funds owed to them, it does not seem that there is a process whereby concerns about such risks can be raised by treating clinicians to the Department of Work and Pensions. A specific concern relates to the potential that individuals, without capacity to manage their finances, may come into receipt of funds which place them at particular risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe the addressees 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 30 August 2019. 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 (a) Mr Boamah's family (b) Camden and Islington 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 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	**5/7/19** **Assistant Coroner R Brittain**