MR G IRVINE
ACTING SENIOR CORONER
EAST LONDON
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Telephone 020 8496 5000 Email [redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Ministerial Correspondence and Public Enquiries Unit** **Department of Health and Social Care, 39 Victoria Street, London, SW1H 0EU** **Email:** coronersreports@dhsc.gov.uk 2. [redacted] **Chief Executive Officer, Camden and Islington NHS Foundation Trust** **4 St Pancras Way, London NW1 0PE** **Email:** [redacted] 3. [redacted] **Chief Executive Officer, East London Foundation NHS Trust** **9 Alie St, London E1 8DE** **Email:** [redacted] 4. **The Commissioner of Police of the Metropolis, Metropolitan Police Service,** **New Scotland Yard, Broadway, London, SW1H 0BG** **Email: new.scotland.yard@met.police.uk**
1	**CORONER** I am Graeme Irvine, acting senior coroner, for the coroner area of East 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST**

	On 13th December 2018 Ms Nadia Persaud opened an investigation touching upon the death of Mr Rohan Dayal Singh, a man aged 31 years old. Ms Persaud opened an inquest on 13th January 2019, the inquest was heard, before a jury commencing on 6th April 2021 and concluding on 16th April 2021. The conclusion of the inquest was a short form conclusion of drug related death contributed to by neglect. The medical cause of death was found to be; 1.a. Ketamine, Gamma-Hydroxybutyrate, Lorazepam, Clonazepam and Promethazine toxicity.
4	**CIRCUMSTANCES OF THE DEATH** On the 10th December 2018, Mr Singh was detained by police under S.136 Mental Health Act. He was searched, no controlled substances were found on his person but a bracelet made of a length of knotted parachute cord, concealing a blade was seized. Mr Singh was conveyed to a place of safety, a local A&E department where he was assessed, on the morning of 11th December 2018, to require treatment pursuant to S.2 Mental Health Act. Mr Singh was transferred to a specialist mental health unit, where, following admission his property was searched. Again, no controlled drugs were discovered. On the ward, Mr Singh's behaviour was aggressive and challenging. The patient was made subject to 15 minute observations. The observations were not adequately undertaken and records of the observations were falsified. On the morning of 13th December 2018 Mr Singh was restrained and administered rapid tranquilisation by intra-muscular injection. Whilst under restraint, Mr Singh was subjected to a personal search and a small vial of liquid was found in his sock, when challenged as to its contents, Mr Singh replied, "nothing to worry about." No steps were taken to establish the nature of the liquid. No other controlled drugs were found. Following, rapid tranquilisation, appropriate mandated monitoring procedures were not followed and records, again, were falsified. Later that morning Mr Singh was found unresponsive on the floor of his bedroom. Despite prompt CPR he could not be resuscitated and was declared dead. Mr Singh was once again in possession of the bracelet confiscated by police on 10th December 2018. A post- mortem examination was undertaken. During a skin level search the pathologist found, amongst other items, quantities of controlled drugs including cocaine, GBL and ketamine, concealed in Mr Singh's underwear. Toxicological analysis of blood samples taken from Mr Singh after death found toxic levels of GHB and ketamine, along with evidence of recent cocaine usage.
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. Rohan Singh died on a mental health ward, following his death he was found to be in possession of number of prohibited items including controlled drugs and a bracelet consisting of a ligature and a blade. Before admission into hospital, Rohan had been subject to a personal search by police officers when the bracelet was seized. During Rohan's admission his property was subjected to a search and later he himself was searched for contraband, despite these steps he retained dangerous contraband. 2. Mr Singh was subject to intermittent observations at 15 minute intervals during his admission. The records of these observations were found to be unreliable, staff accepted that they had failed to undertake observations and made false records, further they had done so in such circumstances that their peers were aware of the falsehood. A culture of impunity existed where inaccurate and misleading recording of clinical records was tolerated. 3. Mr Singh was subject to rapid tranquilisation, following administration of this medication, staff failed to follow the Trust's monitoring process or complete relevant documentation. The failure to monitor Rohan was found by the jury to have contributed to his death. Trust evidence demonstrates that beyond this incident, throughout the organisation the processes are not being universally followed.
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 **25th June 2021**. 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 the family of Mr Singh, the Care Quality Commission and the Nursing and Midwifery Council I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**[DATE]** 30/4/21 **[SIGNED BY CORONER]**