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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Ministerial Correspondence and Public Enquiries Unit** **Department of Health and Social Care, 39 Victoria Street. London, SW1H 0EU** [redacted] [redacted]**, Chief Executive, ELFT, East London Foundation NHS Trust, 9 Alie St, London E1 8DE** [redacted] [redacted]**, National Medical Director, The National Quality Board, NHS England,** [redacted]
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 31st July 2019 Ms Nadia Persaud opened an investigation touching upon the death of Mr Jason Lennon, a man aged 37 years old.

	Ms Persaud opened an inquest on 15th August 2019, the inquest was heard, before a jury commencing on 17th January 2022 and concluding on 11th February 2022. The conclusion provided by the jury was a narrative conclusion arrived at through a questionnaire. The Jury made the following conclusions; • Failures in Jason's community mental health care contributed to his death, • Restraint used by security officers at the Excel centre contributed to Jason's death, • Although the use of restraint by the security officers was necessary, the extent and manner of that restraint was unreasonable, specifically; the level of force used, the location of the restraint - on the floor, Jason's position – prone, and finally, the duration of that restraint. The medical cause of death was found to be; 1.a. Cardiorespiratory Arrest in association with Restraint and Acute Psychotic Episode
4	**CIRCUMSTANCES OF THE DEATH** Jason Lennon was a 37-year-old man who lived in supported accommodation, he had a medical history of; anoxic brain injury and enduring schizophrenic illness. Mr Lennon had a history of periodic relapse resulting in acute psychosis and an associated increased risk of harm to self and others, these relapses resulted in periods of involuntary inpatient treatment under Mental Health Act section. On 28th July 2019 Mr Lennon assaulted another resident at his accommodation, support staff assessed that Jason was in relapse, he was delusional, agitated and paranoid. Support staff reported the incident to the police and the local mental health services, the East London Foundation NHS Trust ("ELFT") Community Recovery Team ("CRT"), a drop-in review was arranged at the CRT offices on 29/7/19. Nursing staff at the CRT undertook a review of Mr Lennon, the patient left the meeting prior to its conclusion. The CRT assessed that Jason's mental state was stable and he was not in crisis. On 31st July 2019 Mr Lennon left his accommodation at 06.55hrs and proceeded to Prince Regent's Lane. A total of 13 separate 999 calls were made to the police over the next 35 minutes reporting Jason's conduct. The calls described Mr Lennon acting in an unusual and confrontational manner, assaulting bystanders and walking into traffic. Police officers responding to these calls were directed to the Excel Centre. Jason had entered the premises as a trespasser, pursuing a member of the public at 07.29 and had been restrained by security staff at the venue. Officers found Mr Lennon at 07.35, on the floor, being restrained in a prone position by a number of security officers. Jason was found to be unresponsive, checks made found him not to be breathing, no pulse could be located. Cardio-pulmonary resuscitation was commenced and very swiftly, the London Ambulance service attended. Advanced Life Support was commenced and Jason was transferred to hospital. Treatment continued at the hospital, however at 09.31 further resuscitative efforts were deemed futile and life

	was pronounced extinct.
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 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. Expert psychiatric evidence indicated that Mr Lennon was a suitable candidate for the Care Programme Approach mental health pathway and that the use of this pathway would have reduced the risk of an acute deterioration in his mental state. The CRT failed to effectively monitor whether Mr Lennon was on a care pathway appropriate to his needs. 2. The CRT undertook a flawed review of Mr Lennon's mental state on 29/7/19 which failed to assess that, Jason was in relapse and was a risk of harm to himself and others. Factors which contributed to this failure included; a. CRT staff did not effectively review medical records prior to assessing Jason, b. The CRT did not communicate important clinical information between themselves and external stakeholders, c. The CRT did not adequately document important information arising from the assessment. 3. The Trust undertook a serious incident investigation report into the events leading to Mr Lennon's death in November 2019 which made a series of recommendations for action. The action plan was found to have been incomplete by 6/2/22 due to errors attributable to the Trust's governance team. 4. Accepted individual failings by staff within the CRT fall below standards set by their regulator. There is no evidence before the court to assess whether ELFT have considered the necessity to make a referral to a regulator.
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 **13th April 2022**. 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 Lennon, the CQC and The Nursing and Midwifery Council. I have also sent it to the local director of Public Health who may find it useful or of interest. 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] 15/02/2022** **[SIGNED BY CORONER]** **PP Ms N. Persaud, Area Coroner**