Karen Dilks
Senior Coroner for the City of Newcastle upon Tyne

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **The Chief Constable for Northumbria Police** **Middle Engine Lane** **Wallsend** **NE28 9NT**
1	**CORONER** I am Carly Elizabeth Henley, Assistant Coroner for the coroner area of Newcastle upon Tyne & North Tyneside.
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 21st January 2020 an inquest was opened into the death of Ewan Nathanial Brown. On 1st October I resumed the inquest, hearing evidence over the course of 11 days. I concluded that Ewan died on 30th April 2019 by accidental drowning in the Culvert under Byker Bridge in Newcastle Upon Tyne. At the time of his death he was suffering from an unassessed and untreated psychotic illness which rendered him incapable of making safe decisions about his welfare.
4	**CIRCUMSTANCES OF THE DEATH** Ewan Nathanial Brown (born 23.5.91) then aged 27 years old was deaf and used two hearing aids. He had no previous mental health history or history of substance or alcohol misuse. On 27th April 2019 he was arrested for Breach of the Peace for acting in a "disturbed manner". Clear concerns about his mental health were noted. He was detained at Forth Banks Police Station, where his detention was authorised from 2.23pm

	on 27th April 2019 until 2.20pm on 28th April 2019. During the time that Ewan was in Police custody he was briefly assessed by a mental health nurse employed by Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust. Concerns about his behaviour whilst in custody were such that arrangements were made for Ewan to be assessed to determine whether he should be detained under the Mental Health Act for further assessment in a hospital setting. Prior to such an assessment taking place, the assessment was stood down and he was ultimately released from custody with a follow up assessment planned with the Crisis Team on 29th April 2019 at the home of his Mother, [redacted] On 29th April 2019, [redacted], Ewan's brother, contacted the Police reporting concerns about Ewan's mental health. Ewan had assaulted his mother and brother. The Police attended but Ewan absconded from the address prior to their arrival. Ewan had not been assessed by mental health services prior to him absconding. Nurses from the Crisis Team attended at the Mother's address, shortly after it was discovered that Ewan had left. Northumbria Police conducted a search for Ewan. By the time he was located on 30th April 2019 he had died.
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. There is no joint policy in place to give guidance to Northumbria Police officers and health professionals in order to enable them to work together and share information about an individual when reported missing, who is classed as vulnerable and is potentially a risk to themselves or others, as a consequence of a mental health difficulty or mental illness. I heard evidence that 30% of missing persons suffer from some form of mental health difficulty. The mental health of a missing person is a crucial aspect of any risk assessment, both in assessing the level of risk they pose to themselves and to others. 2. There is currently no structure in place at a local or national level to allow for a multiagency meeting or meetings to take place when an adult or child is reported missing to the Police. Such a meeting would be a vital source of information to inform missing person risk assessments and to gather intelligence about where the missing person may be. 3. There is no mandatory refresher training for Police Officers in relation to mental health issues, learning disability and autistic

	spectrum disorder. After their initial training, when officers join the Police Force, such further training is optional but not compulsory. Given the prevalence of mental health issues in society and the complexities of dealing with such issues for officers of all ranks and across all areas of policing, this is an issue that all officers would benefit from at regular intervals. 4. I heard evidence from police officers and mental health professionals that indicated a clear lack of awareness that confidential medical information could be requested and shared with police by General Practitioners and Mental Health Professionals when a person is missing. There is a need for training in respect of this across both agencies. 5. Northumbria Police accepted that during the period of time that Ewan was classed as a Medium Risk missing person, no officer was allocated as a point of contact for the family. This prevented information being given by the family that could have better informed the progress of the search and Ewan's risk assessment as a missing person.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 5 January 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: • Mr Brown's family • Newcastle City Council • Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust • Northumbria Police • 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	**10 November 2020** **C E Henley**