REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Central & North West London NHS Foundation Trust (CNWL)** **2. The Chair of the Independent Monitoring Board (IMB)**
1	**CORONER** I am Chinyere Inyama, Senior Coroner for the coroner area of West 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** On 5th November 2012 an investigation was commenced into the death of Prince Kwabena Fosu. The investigation concluded at the end of the inquest on 2nd March 2020.The conclusion of the jury at inquest was : " The control points put in place to protect vulnerable detainees at Harmondsworth IRC were grossly ineffective . There was a gross failure across all agencies to recognise the need for and provide appropriate care in a person who was unable to look after himself or change his circumstances. Mr Fosu died from a sudden death following hypothermia, dehydration and malnourishment with psychotic illness. This was in part due to the failure to assess, recognise, monitor and respond to Mr Fosu's deteriorating condition. Neglect contributed to the cause of death" The jury determined that the medical cause of death was: "A sudden death following hypothermia, dehydration and malnourishment in a man with psychotic illness"
4	**CIRCUMSTANCES OF THE DEATH** Mr Fosu was being held in a single cell at Harmondsworth IRC when he was found unresponsive in that cell on 30th October 2012

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. **CNWL** - All staff who would be expected to refer cases to healthcare need as much assistance as possible in order to discharge that responsibility effectively. It is recognised CNWL is the new healthcare provider and did not provide healthcare in 2012. It is also recognised that CNWL have improved the training on how to make a referral. However, there was knowledge on how to make a referral in 2012 and the jury have highlighted the failures that still occurred, leading to the death of Mr Fosu . My concern centres on improving the recognition of when to make a referral as opposed to knowing the mechanics of making a referral once a decision has been made to refer. By way of respectful analogy, medical practitioners referring cases to a coroner know *how* to make a referral but now have guidance in legislation as to *when* to refer. The Trust should give serious consideration to developing a guide to all staff on when to refer cases to healthcare. This should be achievable without being either over-prescriptive or over-restrictive. 2. **IMB**- The current practise remains to refer concerns around detainees only to the Home Office contract monitor. I see no good reason not to, in addition and simultaneously, report concerns to the healthcare managers at the IRC. In recording this concern I have in mind the jury's determinations and findings in the record of inquest which highlight ineffective joint working across all agencies. Simultaneous reporting of issues would lessen the prospect of a healthcare related issue slipping through the net and not being addressed.
	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 31st August 2020. 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 Person: 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	**DATE: 6th July 2020** **SIGNATURE:**