



for Bedfordshire and Luton

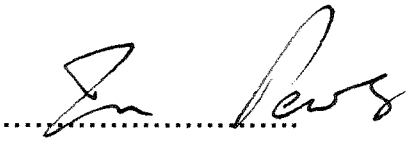
## REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	<p><b>THIS REPORT IS BEING SENT TO:</b></p> <p><b>The Chief Executive</b> East London NHS Foundation Trust Corporate Headquarters 9 Alie Street London. E1 8DE</p>
1	<p><b>CORONER</b></p> <p>I am <b>IAN PEARS</b>, Acting Senior Coroner, for the coroner area of Bedfordshire &amp; Luton</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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.</p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 1<sup>st</sup> December 2016 I commenced an Investigation into the death of <b>LUKE ALF EDWARD MOULDING</b> aged 29. The Investigation concluded at the end of the Inquest on 5<sup>th</sup> April 2017. The Conclusion of the Inquest was '<b>ACCIDENTAL DEATH</b>'. The medical cause of death was:</p> <p>1 (a) Severe Traumatic Injuries 1 (b) 1 (c) II Excess Alcohol, Cannabinoids and Opiates Intake</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>On the 25<sup>th</sup> November 2016 the Deceased entered the railway line near his home in Westoning in Bedfordshire, having consumed alcohol and drugs. Prior to his death he rang his mother and informed her he was going to get noticed so</p>

	<p>he could be arrested and then be helped. In the event he collided with a train and died from severe traumatic injuries.</p>
<p>5</p>	<p><b>CORONER'S CONCERNS</b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <ol style="list-style-type: none"> <li>(1) The Deceased saw [REDACTED], Speciality Doctor in Psychiatry, at Beacon House Community Mental Health Team on 11<sup>th</sup> November 2016. The deceased left part way through the consultation. [REDACTED] decided an “opt in” letter was required. It was not sent.</li> <li>(2) The evidence is that “opt in” letters are “normally typed and sent by 10 working days.</li> <li>(3) There seems to be no reason why a typed letter is required. A pre-printed letter/brochure/card would suffice and give the service users sufficient information, should they require it.</li> </ol>
<p>6</p>	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe East London NHS Foundation Trust have the power to take such action.</p>
<p>7</p>	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this Report within 56 days of the date of this report, namely by <b>15<sup>th</sup> June 2017</b>. I, the Coroner, may extend the period.</p> <p>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.</p>
<p>8</p>	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [REDACTED]</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>The Chief Coroner may publish either or both in a complete or redacted or</p>

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 Dated 13<sup>th</sup> day of April 2017

A handwritten signature in black ink, appearing to read 'Ian Pears', written over a horizontal dotted line.

**IAN PEARS**  
Acting Senior Coroner  
for the coroner area of Bedfordshire & Luton

