Senior Coroner - Emma Whitting
Bedfordshire & Luton
REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: 1) [REDACTED] Chief Executive Officer, NHS England and NHS Improvement [REDACTED], Chief Executive, East London NHS Foundation Trust ("ELFT")
1	**CORONER** I am Tom Stoate, Assistant Coroner for the area of **Bedfordshire and Luton**.
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 5 January 2021 an investigation was commenced into the death of Mr Thomas Antony Smith (hereafter where relevant "Thomas"), aged 33. The investigation concluded at the end of the inquest (held with a jury) on 1 April 2022. The conclusion of the inquest was a narrative conclusion as follows: *"Thomas died of a drugs related death as a result of a series of serious failings in his care"*
4	**CIRCUMSTANCES OF THE DEATH** The jury empanelled for this inquest found the circumstances of Mr Smith's death to be as follows: *"Thomas died in part due to serious failings in the care given to him on Coral Ward during the night of 29th/30th December 2020 following a positive drugs test around 8:30pm on 29th December 2020.* *Thomas was granted Section 17 accompanied leave to go into Luton in the afternoon of 29/12/20. Following a visit to a Post Office, Thomas visited a vape shop where he possibly obtained [REDACTED], before returning to Coral Ward.*

	Concerns in Thomas's presentation prompted a urine drugs test at 8:30pm which was positive. Accordingly [sic] *to ELFT policy, this should have triggered increased observations of Thomas. This was not done.* *Other serious failings were:* *- Lack in knowledge of Trust staff relating to patients who had tested positive for drugs* *- The level of observations on Thomas was not increased and were insufficient following assessment of him by the duty on-call doctor around 11:20 on 29/12/20* *- Signs of potential deterioration in Thomas were not identified* *- Thomas's presentation and unidentified material found in his room which may have been illicit drugs at around 02:40 on 30/12/20, were not escalated to more senior members of ward staff.* *There was an admitted failure in starting CPR on Thomas for a period of approximately 2 minutes after he was found unresponsive in his room at approximately 07:34am on 30/12/20, although this failure did not cause or contribute to Thomas's death.* *A possible cause contributing to Thomas's death was the visit to the vape shop on escorted leave under Section 17 on the afternoon of the 29/12/20."* The cause of Mr Smith's death was determined to be: Ia Aspiration of Gastric Contents Ib [redacted] [redacted] misuse Ic II Cardiac hypertrophy and Dilatation
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) Knowledge of the dangers of [redacted] in detained mental health patient settings There was evidence of steps having been taken by the ELFT at a local level to remedy the apparent lack of knowledge amongst its staff regarding the dangers of [redacted]' and [redacted] after Mr Smith's death, including its own substance misuse training and inviting local substance misuse charities back onto its wards to work with its patients and staff as Covid restrictions lift.

There was, however, various evidence which suggested a lack of knowledge from ELFT staff around [redacted] and it's potentially fatal effects, including that several witnesses:

(i) Did not know what '[redacted]' or [redacted] could look like;

(ii) Were unaware of how of a person under the influence of '[redacted]' or [redacted] might present; and

(iii) Had received no training on the dangers of '[redacted]' or [redacted]

There was some evidence that this might be a wider issue of concern, both locally and nationally, than only with ELFT staff. In the event that is correct, this report is directed to NHS England and NHS Improvement.

2) <u>The system for assessing risks associated with s.17 leave</u>

I was told that, when a staff member is escorting a service user out of the ward, there is an expectation for that staff member to be aware of the location, general mental state and wellbeing of the service user; and that a 'mental state assessment' should be carried out on the ward prior to leave taking place, as a further safeguard once s.17 leave had been granted.

However, the evidence of the healthcare assistant who took Mr Smith out on leave, on the occasion (29 December 2020) that the jury concluded it was possible that he was able to buy the [redacted] the misuse of which caused his death, was that:

(i) He would not necessarily read a patient's RiO (electronic continuous) notes before taking a patient out on leave;

(ii) He had not read Mr Smith's care plan before taking him on leave;

(iii) There had been no handover from other staff to him of Mr Smith's presentation on 28 December 2020 presentation (when he was suspected of being 'under the influence' of a substance); and

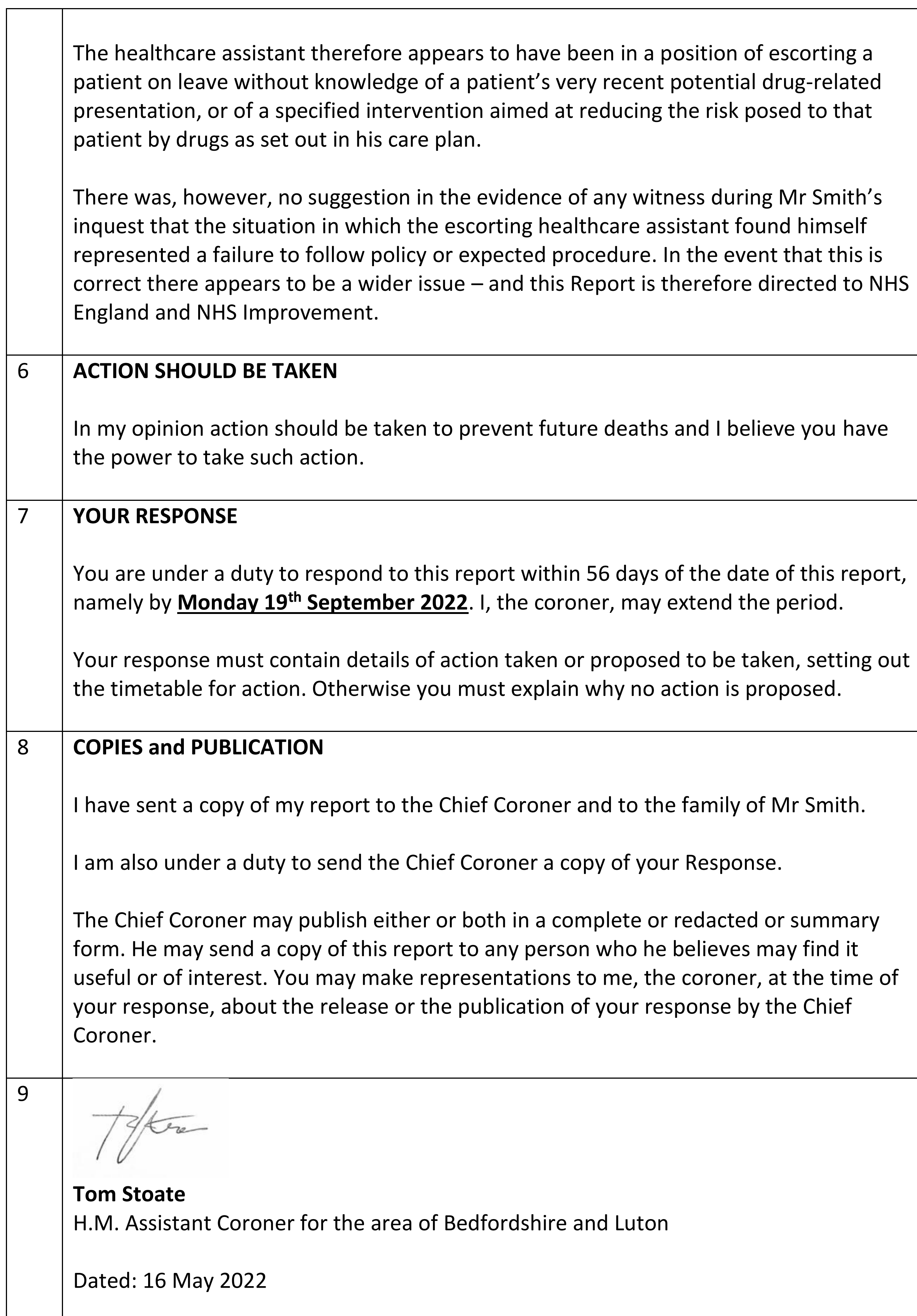
(iv) Although he had read the form authorising Mr Smith's leave (i.e., the s.17 form), that form – a statutory document – does not contain information about particular risks posed to a patient by or when out on s.17 leave.

As a result of the above, this particular healthcare assistant was unaware that:

(i) On 28 December 2020 Mr Smith had been suspected of being under the influence of drugs;

(ii) Mr Smith's care plan of 20 December 2020 set out as a 'risk issue' the fact that "*Thomas has a history of using illicit substances*"; and

(iii) The care plan set out as an 'intervention' for Mr Smith: "*Nursing staff to do random urine drug screening and breathalysing upon return to the ward*."



	The healthcare assistant therefore appears to have been in a position of escorting a patient on leave without knowledge of a patient's very recent potential drug-related presentation, or of a specified intervention aimed at reducing the risk posed to that patient by drugs as set out in his care plan. There was, however, no suggestion in the evidence of any witness during Mr Smith's inquest that the situation in which the escorting healthcare assistant found himself represented a failure to follow policy or expected procedure. In the event that this is correct there appears to be a wider issue – and this Report is therefore directed to NHS England and NHS Improvement.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 **Monday 19th September 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 family of Mr Smith. 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	**Tom Stoate** H.M. Assistant Coroner for the area of Bedfordshire and Luton Dated: 16 May 2022