Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted] CEO Bedford Hospitals NHS Foundation Trust**
1	**CORONER** I am Emma WHITTING, Senior Coroner for the coroner area of Bedfordshire and Luton Coroner Service
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 09 December 2021 I commenced an investigation into the death of Yuksel Bedri ISMAIL aged 23. The investigation concluded at the end of the inquest on 24 August 2022. The Narrative Conclusion of the inquest was that: After absconding from a nearby hospital, the Deceased was struck by an HGV on the M1 and suffered fatal injuries.
4	**CIRCUMSTANCES OF THE DEATH** Shortly before 19.30 hours on 28 November 2021, the Deceased was witnessed to run into the path of an oncoming HGV on the M1 motorway. Despite the driver of the HGV taking all possible avoiding action, the Deceased was struck by the front nearside of the HGV and was fatally injured; although, he was taken by paramedics to the Luton & Dunstable Hospital, his death was confirmed at 20.30 hours. He had been admitted to the Luton & Dunstable Hospital earlier that day after having been found in a vulnerable state and had been assessed by the Psychiatric Liaison Team as being psychotic, lacking in mental capacity, and in need of a MHA assessment. In view of his vulnerability, the Psychiatric Liaison Service staff had also requested the Accident and Emergency Staff to provide him with 1:1 observation as they were concerned about him leaving the hospital. Whilst still awaiting a full MHA assessment, shortly after 19.00 hours, he had been transferred by the same member of staff carrying out the 1:1 observation to a Ward but, during the transfer, had absconded and exited the hospital site heading towards the M1.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern)

	1. The Court was told that an SI investigation had not been completed by the Trust in this case; however, the PEARL Meeting on 3 December 2021 acknowledged that "*the current transfer policy needs reviewing...the transfer policy implemented around the mental health patients should be prioritised as there are risks involving patients and staff, all depending on the assessment of the patient*". Despite this and ELFT's own SI Report (disclosed to the Trust before the PIRH held on 26 May 2022) having highlighted the need for PLS staff to be involved in any decision regarding patients waiting for MHA assessment, or who may need to be conveyed to another area within the hospital site as 'such patients are high risk and often unpredictable', by the start of the Inquest held on 24 August 2022, there was no evidence of Bedford Hospitals NHS Trust's acceptance of the recommendations made. Whilst at lunchtime on the day of the Inquest itself, the Court was provided with a draft of a new Transfer Policy, this Policy still did not appear to have addressed the main issue: - Whilst it includes "Confused, disorientated, self-harming, suicidal or displaying erratic or aggressive behaviours" and "patients at risk of absconding" in the list of 'At risk' patients in Section 3, the needs of such patients are still not addressed in the Assessment Tool (Appendix 4) nor is the need for consultation with the PLS staff about any of the escort/transfer arrangements. 2. Although ELFT's SI Report (disclosed to the Trust before the PIRH held on 26 May 2022) had highlighted that "*There is a need for staff involved in transferring patients, including security staff, to have training in the exercise of the Mental Capacity Act to ensure that patients who are assessed as lacking capacity with identified risks to self are unable to leave the emergency department*" and recommended that "*training be provided to acute Trust colleagues on the application of the Mental Capacity Act, its use to restrain/prevent somebody leaving the department if they are deemed to lack capacity and there are concerns regarding their risk should they leave, and where the person has capacity but remains a risk to the themselves*", there was no evidence before the Inquest of Bedford Hospitals NHS Trust's acknowledgment or consideration of this. Instead: - The Court heard from several Trust witnesses including a ED Sister, that they considered they had no powers to detain someone within the ED; - The statement provided to the Inquest by the ED Lead, [redacted] (provided to the Court along with notice that he would NOT be available to attend the Inquest even though at the PIRH the Court had made it clear that the witness providing evidence of relevant Trust Policy would need to attend the Inquest) appeared confused about the powers available: Para 12 "*Physical restraint is permitted in circumstances where the patient is confirmed to lack mental capacity and the* *restraint is necessary to preserve life or health and is proportionate to risk*" Para 17 "*Even if a single security officer had assisted with the transfer, they would be unable to physically restrain as the* *restraint policy specifies a minimum of two security officers are required for this and Mr Ismail was not subject to lawful DOLS at that point*"; - PLS Staff stated that they have known of other patients leaving the ED whilst awaiting a MHA assessment
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 October 20, 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 [redacted] **Chief Executive ELFT -** [redacted] I have also sent it to **PC** [redacted] 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 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 by the Chief Coroner.
9	**Dated: 25/08/2022** **Emma WHITTING** **Senior Coroner for** **Bedfordshire and Luton Coroner Service**