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 NHS England and NHS Improvement (North)**
1	**CORONER** I am Ian PEARS, HM Assistant Coroner for the coroner area of West Yorkshire Western Coroner Area
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 03 September 2019 I commenced an investigation into the death of Ben Alan SHIPLEY aged 22. The investigation concluded at the end of the inquest on 23 February 2023. The conclusion of the inquest was that: Ben Alan Shipley died on 29th August 2019 having been struck by a train at Milne Viaduct East End after absconding from Huddersfield Royal Infirmary's Clinical Decisions Unit at 12.30. Ben voluntarily came to A&E on 28th August 2019 at 19.27 after suffering a mental health crisis. He was assessed by 2 mental health psychiatrists and a mental health nurse. He was deemed to require a section 2 detention under the Mental Health Act, but was to remain in A&E for his own safety until a bed was sourced. After a prolonged search, using various communications methods, for a bed lasting approximately 17 hours, Ben absconded from A&E, where he traveled to a railway, [redacted]
4	**CIRCUMSTANCES OF THE DEATH** Ben is a 22yr old single man who lived with his family in Lepton, Huddersfield. On the 28th of August Ben was seen by his GP who referred Ben to the 'Single Point of Access' service. On the 29th of August Ben was at the hospital with is parents, waiting to be sectioned under the mental health act when he ran away. His parents reported him as a missing person. That afternoon Ben was struck by a train in a rural area of Huddersfield. His life was pronounced extinct at 14:14hrs.
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) Ben was assessed at 22.00 on 28th August 2019. It seems to me that there are about 12 hours of delay following a 22.00 s2 Mental Health Act assessment built into the system if

	there is no bed. Presumably this would be longer if Ben had been assessed earlier in the night shift. I am told beds do not become available over night. This means Ben cannot be legally detained as the section 2 is not complete until there is a bed. He is therefore subject to the goodwill of the A&E (who are not trained in mental health) and the goodwill of the family (who are similarly not trained in mental health). [redacted]
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 April 28, 2023. 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] I have also sent it to **Calderdale and Huddersfield Foundation Trust** **Kirklees Council** **South West Yorkshire Partnerships NHS Foundation Trust** 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: 27/04/2023** **Ian PEARS** **HM Assistant Coroner for** **West Yorkshire Western Coroner Area**