REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chief Executive NHS Kent and Medway Clinical Commissioning Group** **2. [redacted], Chief Executive NHS England**
1	**CORONER** I am Catherine Wood, assistant coroner, for the coroner area of North East Kent.
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 the 21 February 2022 an inquest was opened into the death of Benjamin Henry Hazelden. At the inquest, which was a wider article 2 compliant inquest and lasted four days the court heard from several of those involved in Benjamin's short life, I concluded on 13 July 2023 with a narrative conclusion "Ben died as a consequence of his own actions during an episode of disturbed dissociative behaviour whilst waiting for a specialist bed to be procured in the community as a consequence of a failure to procure and provide a suitable inpatient bed to meet his needs."
4	**CIRCUMSTANCES OF THE DEATH** 1. Ben Hazelden had a complex history including dyspraxia, autistic spectrum disorder, anxiety with depression and post traumatic stress disorder, the latter being due to having been abused earlier in his life. He suffered from dissociative episodes where he had at times harmed himself and others but otherwise was engaging and well-liked by those who met him. He was also in the process of seeing a neurologist given a family history of Huntingdon's disease. He was admitted to hospital as a 17 year old and transferred to adult services on reaching 18. A package was put in place for him to be transferred to the community with support from a private care provider with two members of staff being with him 24hours a day in March 2021. He initially did well and had also been seen by a psychologist from Kent and Medway Complex Autism service and was undergoing some therapy with a view to reducing his risk and stabilisation of his presentation prior to considering any long term trauma work. He had a deterioration in his mental health in July 2021 and was admitted under the provisions of the Mental Health Act to St. Martin's hospital in Canterbury. 2. He returned home in August and the dissociative incidents continued but were manageable until the end of the year when there were concerns over the increasing frequency and risks. In January 2022 he had taken himself onto train tracks near his house and was taken to the Queen Elizabeth the Queen Mother hospital and assessed by liaison psychiatry who did not consider he had an acute

	treatable mental health problem. He stayed at Queen Elizabeth the Queen Mother hospital whilst discussions ensued between the agencies involved in his care including Kent County Council, Kent and Medway NHS and Social Care Partnership Trust, Avondale, the Integrated care board and East Kent hospitals NHS Trust. Attempts were made to obtain a specialist bed and a Mental Health Act assessment on 28th January 2022 deemed him not to be detainable under the provisions of the Mental Health Act although the possibility of an informal bed was suggested as an interim solution. Ultimately it was decided that he should be discharged home with an increased package of care and now 3 carers. 3. He went home on 3rd February and on 11th February he assaulted two members of staff and ran to the nearby train station placing himself on the tracks where sadly a train coming into the station hit him. He died from his injuries at the scene.
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 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. – 1. In the course of hearing the evidence it was clear that young adults with autism who were at risk of self-harm as well as harm to others have very limited options in terms of placements where their needs can be met. A bespoke placement had been carefully created by those involved in Ben's care but this had taken several months to arrange. This arrangement had worked well and all involved tried to make it a success and for quite some time it was. It was however recognised that there may come a time in the future when his risks to himself and others would mean an alternative placement would be needed. 2. When Ben's risks to himself increased further there were no suitable beds available where he could be cared for in an environment which could meet his needs. He spent several days in an acute hospital bed despite being medically fit for discharge which although, essentially a place of safety, was totally unsuited to his needs. This stay continued whilst discussions ensued regarding where he should be placed. A bed in an acute psychiatric ward was considered but not deemed appropriate to meet his needs and as there were no specialist beds available he was discharged back to his home with increased support as the best option available. Had a bed been available in a specialist unit it is likely that he would not have died when he did. 3. In the evidence provided it became clear that a lot of units where a specialist bed may have been available had been closed in the past due to concerns about the level of care following a number of investigations. This has led to a system whereby locally and nationally there are limited options for those requiring care relating to both the management of autism and self-harm or harm to others, particularly when there is an urgent need for increased support. Whilst the inquest heard there were some counties who had specialist beds they were difficult to access as they were often full and places were not always available to meet urgent needs
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 22 November 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 namely the family, Avondale Care, Kent County Council, Kent and Medway Commissioning Group, East Kent Hospitals NHS Trust, and Kent and Medway Community Partnership NHS Trust. 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	**26 September 2023**  **Catherine Wood** **Assistant Coroner** **North East Kent**