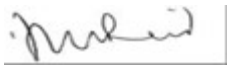
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1) [redacted], Chief Executive, West Midlands Ambulance Service University NHS Foundation Trust, Millennium Point, Waterfront Business Park, Waterfront Way, Brierley Hill, West Midlands, DY5 1LX.
1	**CORONER** I am David Donald William REID, HM Senior Coroner for Worcestershire.
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 17 November 2021 I commenced an investigation and opened an inquest into the death of Rosie Catherine YOUNG. The investigation concluded at the end of the inquest on 8 February 2024. Rosie died on 8 November 2021 at The Queen Elizabeth Hospital, Birmingham from a traumatic brain injury. The jury recorded the circumstances in which Rosie had sustained that fatal brain injury as follows: *"On 7.11.2021 Miss Young was seriously injured when she stepped out from the rear door of a moving ambulance travelling on the A422 Worcester to Stratford Road, near Inkberrow, whilst being transported to Hillcrest Psychiatric Unit, Redditch. She died from her injuries in the Queen Elizabeth Hospital, Birmingham on 8.11.2021."* At the time of these events, Rosie had been detained under s.2 Mental Health Act 1983,and was being transported on vehicle from your Trust, accompanied by staff from your Trust, from the s.136 suite at Newtown Hospital, Worcester to Hillcrest Psychiatric Unit, Redditch. Rosie was a young woman with an extensive mental health history, with established diagnoses of Emotionally Unstable Personality Disorder (EUPD) and Autistic Spectrum Disorder. She had had regular contact with mental health services in Worcestershire, and her EUPD was often characterised by impulsive, risk-taking behaviour, including two incidents earlier in 2021 when she had jumped out of moving vehicles. The conclusion of the jury at the inquest was expressed in two parts. Firstly: *"Rosie Young died as a result of stepping from a moving vehicle. It is not possible to determine what her intention was at the time she did this."* The jury then went on to consider questions relating to potential failings by agencies involved in her care immediately prior to her death. Those questions and the jury's answers were recorded as follows: "*1. Were previous incidents of Rosie jumping from moving vehicles properly recorded in her mental healthcare notes, so that they would have been readily apparent to the*

	Approved Mental Health Professional (AMHP) who was considering her risk of self-harm while being transported to Hillcrest ward on 7.11.21? *NO* *1.1 If NO, did that failure probably cause or contribute to Rosie's death?* *YES* *2. Were previous incidents of Rosie jumping from moving vehicles properly recorded in previous reports by Approved Mental Health Professionals (AMHPs), so that they would have been readily apparent to the AMHP who was considering her risk of self-harm while being transported to Hillcrest ward on 7.11.21?* *NO* *2.1 If NO, did that failure probably cause or contribute to Rosie's death?* *YES* *3. Was the previous incident on 13.5.21, in which Rosie had jumped from an ambulance while being transported to Worcestershire Royal Hospital, properly recorded by West Midlands Ambulance Service (WMAS), so that it would have been readily apparent to WMAS members of staff involved in the arrangements to transport Rosie to Hillcrest ward on 7.11.21?* *NO* *3.1 If NO, did that failure probably cause or contribute to Rosie's death?* *YES* *4. At the time of Rosie's death, had WMAS taken any or any sufficient steps to ensure that their staff were aware of, and trained to apply the terms of their own Mental Health Act Transportation Policy?* *NO* *4.1 If NO, did that failure probably cause or contribute to Rosie's death?* *YES* *5. At the time of Rosie's death, had Herefordshire and Worcestershire Health and Care NHS Trust (HWHCT) taken sufficient steps to ensure that their staff were aware of, and trained to apply the terms of the Mental Health Act Transportation Policy?* *NO* *5.1 If NO, did that failure probably cause or contribute to Rosie's death?* *YES* *6. At the time of Rosie's death, had Worcestershire County Council (WCC) taken sufficient steps to ensure that their AMHPs were aware of, and trained to apply the terms of the Mental Health Act Transportation Policy?* *NO* *6.1 If NO, did that failure probably cause or contribute to Rosie's death?* *YES*

	7. When arranging transport to take Rosie to Hillcrest ward, did the AMHP properly apply the Mental Health Act Transportation Policy and properly assess the risks involved in transporting Rosie to Hillcrest ward? *NO* *7.1 If NO, did that failure probably cause or contribute to Rosie's death?* *YES* *8. When arranging transport to take Rosie to Hillcrest ward, did the AMHP properly convey to WMAS the risks which Rosie might present when being transported?* *NO* *8.1 If NO, did that failure probably cause or contribute to Rosie's death?* *YES* *9. On the morning of 7.11.21 when the ambulance vehicle arrived to take Rosie to Hillcrest ward more than 13 hours after it had originally been requested, should a further updated assessment of the risks involved in transporting Rosie to Hillcrest ward, in line with the requirements of the Mental Health Act Transportation Policy, have been carried out?* *YES* *9.1 If YES, did that failure probably cause or contribute to Rosie's death?* *CANNOT SAY* *9.2 If NO or CANNOT SAY, did that failure possibly cause or contribute to Rosie's death? CANNOT SAY* *10. Were the arrangements made to transport Rosie to Hillcrest ward on 7.11.21 sufficient to meet the risks of selfharm which she posed?* *NO* *10.1 If NO, did that failure probably cause or contribute to Rosie's death?* *YES* *11. If your answer to Question 10 above is NO, were there sufficient personnel in the back of the ambulance vehicle with Rosie?* *NO* *12. If your answer to Question 11 above is NO, which one of the following options should have been used?* *(a) Mental healthcare staff provided by HWHCT to travel in the back of the ambulance vehicle with Rosie?* *(b) Police officers to have travelled in the back of the ambulance vehicle with Rosie?* *YES*
4	**CIRCUMSTANCES OF THE DEATH** See above.

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) Over the course of the inquest, it was quite apparent that few, if any, of the witnesses who gave evidence, including several employees of your Trust, were familiar with the version of the Mental Health Act Transportation Policy which was in force at the time of these events. This Policy governed the assessment of the risk involved in transporting a patient detained under the Mental Health Act 1983 (the MHA) to a psychiatric unit, and stipulated the measures to be deployed to mitigate that risk; 2) The witness who presented your Trust's internal investigation report into the events surrounding Rosie's death told the inquest: *"None of our employees would have received specific training about the Transportation Policy – I accept that means this crew would not have known to ask for the Risk Assessment Tool* [an important document provided in the Policy to assess the risk posed by the patient to be transported]*. I would have thought they would have known to ask for the Written Authority to Transport* [another important document provided in the Policy, by which the Approved Mental Health Professional (AMHP) delegates responsibility for the detained patient to those transporting her]*, as they do receive training about that. If they didn't know about either of those forms, I accept that they may not have been an appropriate crew for this job."* 3) It seems that your Trust appeared at the time of these events to have had no system in place to ensure that those of your employees who dealt with the transportation of patients detained under the MHA were familiar with and trained to apply the provisions of the version of this Policy which was in force at the time. It is of concern therefore that if that remains the case, not only in relation to the MHA Transportation Policy, but in relation to other policies and procedures under the MHA, circumstances creating a risk of other deaths will occur, or will continue to exist, in the future.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, as the Chief Executive of the West Midlands Ambulance Service University NHS Foundation Trust, 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 **12 April 2024.** 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: (a) [redacted], Rosie's parents;

	(b) [redacted], National Medical Director, NHS England. 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	**16 February 2024**  **David REID** **HM Senior Coroner for Worcestershire**