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NHS Devon Response to Regulation 28 Report to Prevent Future Deaths
To: HM Coroner Mr Spinney
In the matter of: Benjamin Robert Compton
Coroner's Case Reference: [redacted]
Date of Regulation 28 Report: 19th March 2025
Date of NHS Devon Response: 4th June 2025

Dear Mr Spinney,

NHS Devon acknowledges receipt of the Regulation 28 report following the inquest into the death of Benjamin Robert Compton. We would first like to extend our condolences to Benjamin's family, friends, and all those who cared for and supported him. We recognise the impact of his death and the importance of the coroner's concerns in ensuring future improvements to the health and care system. This letter sets out NHS Devon's response to the matters of concern you have identified.

Matters of Concern and Responses

Concern 1:
The evidence reveals that there was a gap in the provision of care for individuals suffering with autism and in crisis, that remains the case today both in Devon and nationally. Evidence was heard that a gap exists with autistic people in distress and or dysregulation with no treatable mental health condition and there is a grey area around treatment. This is beyond the skills of social care providers. And unless the individual meets the criteria for treatment under the Mental Health Act there is very little support.

Consideration should be given to reviewing the process of supporting and providing interventions to those individuals suffering with autism and in crisis.

Response:
Devon ICB recognises the existing commissioning gap for individuals with autism who experience crisis. In response, significant work has been undertaken in 2023–2024 to

raise awareness and implement reasonable adjustments to better meet their mental health needs.

In 2022, Devon received capital investment to develop a new community inpatient service dedicated to people with learning disabilities and autism requiring mental health treatment. This regional centre, one of two in the Southwest, aims to become a centre of excellence providing specialist expertise, training, and system-wide support. The first inpatient beds are scheduled to open in June 2025.

Alongside this, an outreach and inreach service will be integrated into the pathway to prevent unnecessary admissions and ensure timely, appropriate care.

Furthermore, the implementation of the Oliver McGowan mandatory training will enhance community skills and promote reasonable adjustments across services, ensuring that autistic individuals in crisis receive appropriate support.

To review and improve current processes for crisis support, the Learning Disability and Neurodiversity commissioning team will conduct a comprehensive community delivery review in 2025/2026. This review will cover primary care, secondary care, social care, and acute services to optimise care pathways for this population.

A full commissioning review and improvement plan will also be presented to the Devon ICB executive in the last quarter of this financial year.

Concern 2:
Benjamin was removed from his GP practice due to violent behaviour and allocated to the Special Allocation Scheme. This scheme was not able to meet the needs of a patient such as Benjamin with a diagnosis of Autism Spectrum Disorder.

Consideration should be given to ensuring that when patients are allocated to the GP Special Allocation Scheme they are properly assessed as being suitable for the scheme and receive the appropriate clinical care and treatment.

Response:
We have previously made improvements to processes and requirements in this scheme since this case. The changes include reviewing the process the practice has followed to ensure it meets all the requirements for allocation to the Special Allocation Scheme and where an appeal is made, the panel agenda has clear items to check/ensure the practice has followed the appropriate processes for assigning to the scheme.

Regarding the application of our process in this case, we have also reflected previously on this case that a choice should have been given to whether the family wished for the appeal panel to take place, following this person's death, rather than ceasing all communication in an intended act of respect.

Following receiving this Prevention of Future Deaths notice we have additionally considered what extra action can be taken to additionally strengthen arrangements. We have determined to make a modification to the Special Allocation Scheme Standard Operating Procedures (SOP) that specifically requires written confirmation from Practices that they considered all possible alternative approaches to providing primary medical services prior to making the placement. This change was enacted in May 2025.

In summary the death of Benjamin highlights the need for continued improvement in how services respond to autistic individuals in crisis. Devon ICB is committed to taking forward the actions outlined above, strengthening our approach, and working with partners to ensure compassionate, appropriate, and timely support is available when it is most needed.

Should any further information or clarification be required, we would be pleased to provide it.

Yours sincerely,

[redacted]

[redacted]
Primary Care Medical Director, NHS Devon