REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT DATED 19 MARCH 2025 IS BEING SENT TO:** **Devon Integrated Care Board.** **Devon Partnership Trust.** **Director for Primary Care NHS Devon.** **NHS England.** For information: **Family of Benjamin Robert Compton.** **Chief Coroner.**
1	**CORONER** I am Philip SPINNEY, HM Senior Coroner, for the coroner area of The County of Devon, Plymouth and Torbay.
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 10 February 2022 an investigation was commenced into the death of Benjamin Robert Compton. The investigation concluded at the end of the inquest held on 4 -5 March and 10 March 2025. The conclusion of the inquest was as follows: *On 1 February 2022 Benjamin Robert Compton died after being hit by a lorry on the M5, Devon, between junctions 29 and 28.* *Road Traffic Collision*
4	**CIRCUMSTANCES OF THE DEATH** Benjamin was diagnosed with having an autism Spectrum disorder. In September 2021 Benjamin started to suffer a deterioration in his physical and mental wellbeing; according to the evidence this was probably due to an episode of swallowing water in a swimming pool; that event started a pathway of decline over several months. The evidence at the inquest supports the conclusion that the cause was multifactorial and there are a number of possible contributory factors to the deterioration in his health and the escalation in his disruptive behaviour, these included:

	- Aspects of his physical health - His medications - The removal from his GP Practice - Placement on the Special Allocation Scheme - The lack of an effective medication review and - Changes in his routines Benjamin required multidisciplinary input into all aspects of his care planning; including primary care for prescribing medication for emotional wellbeing and pain, from psychology for safe interventions, specialist sensory occupational therapy for communication and interaction with the world. In January 2022 when Benjamin was in crisis, clinical support and advice was limited – he was not able to see a GP, he did not receive a full and effective medication review and in the early part of January 2022 he was not in receipt of a full and effective social care package. The inquest heard evidence about the Devon Adult Autism Intervention Team (commissioned by The Devon Integrated Care Board and operated by Devon Partnership Trust). This team forms part of the Devon Health and Social Care Systems response to the needs of autistic adults across Devon, although it was not fully operational when Benjamin died. The team offers signposting and advice, consultation for professionals and assessment, formulation and provision of direct interventions where needed. This is a clinical team consisting of Psychology, Speech & Language, Occupational Therapy and Psychiatry. However the team is only able to offer limited interventions and not in circumstances where the individual is in crisis. In the early hours of the 1 February 2022, at a time when he was distressed and overwhelmed by his emotions and difficulties tolerating change, Benjamin left his accommodation where he was being supported by carers and walked barefoot and in his night clothes to the M5 where he was hit by a lorry.
5	**<u>CORONER'S CONCERNS</u>** 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) 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. (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.
6	**ACTION SHOULD BE TAKEN** **(1) Consideration should be given to reviewing the process of supporting and providing interventions to those individuals suffering with autism and in crisis.** **(2) 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.** In my opinion action should be taken to prevent future deaths and I believe you and 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 14 May 2025. 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 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. She may send a copy of this report to any person who she 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	**SIGNED:** **Mr Philip C Spinney**

	HM Senior Coroner