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 Calderdale and Huddersfield NHS Foundation Trust** **2 CQC North** **3 NHS England (Reg 28 Reports)**
1	**CORONER** I am Crispin OLIVER, 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 May 2023 I commenced an investigation into the death of Myles Edward SCRIVEN aged 31. The investigation concluded at the end of the inquest on 11 July 2025. The conclusion of the inquest was that: Myles Edward Scriven died a natural death to which neglect contributed.
4	**CIRCUMSTANCES OF THE DEATH** Myles Edward Scriven died at Huddersfield Royal Infirmary on 16 April 2023. Contributing to the cause of his death was lack of adjustments for his Autism and Learning Disabilities resulting in incorrect decision making as to his care and medication.
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) The rider of Neglect attaches to the actions of the Calderdale and Huddersfield NHS Foundation Trust ('the Trust'). It relates to the lack of adjustments, that were identified as being required to treat Myles safely in the context of his Learning Disabilities ('LD') and Autism notably during his admission 20-25 October 2022. It is true that evidence from Trust witnesses has been sufficient to demonstrate that the Trust is aware of the issues arising in this case at least in terms of training and professional input. It has an ongoing programme of training in relation to Learning Disabilities and Autism in clinical care and they have people in post enhancing Learning Disability provision. The crux of the remaining concern is in relation to auditing the impact of all of this in terms of auditing the outcome of this work. To be fair, Trust evidence was that there is now auditing of mental capacity assessments and there is dedicated nursing leadership walkaround of all wards auditing LD and autism policies being applied. However, there is this remaining evidential reality: much of what is now in place was already in place in 2022 – not least key personnel who gave evidence at the Inquest, but also VIP passports, training and all the underlying regulatory underpinning. But in Myles's case it simply had no impact whatsoever. One witness's own

	'spot-on' entries in the EPR on 21 October were just were not acted upon by colleagues and had zero effect when she went on leave thereafter. Clinicians were applying Mental Capacity Act principle 1 but not 2. 'Culturally' speaking, that one obtaining in secondary care after the witness went on leave seems to have been stuck in another era. So, the question is - how it is proposed to ensure full compliance with best practice and by when?
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 September 08, 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 and to the following Interested Persons [redacted] I have also sent it to 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: 14/07/2025**  **Crispin OLIVER** **HM Assistant Coroner for** **West Yorkshire Western Coroner Area**