Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **before** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Chief Executive ELFT -** [redacted]
1	**CORONER** I am Emma WHITTING, Senior Coroner for the coroner area of Bedfordshire and Luton Coroner Service
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** On 23 January 2023 I commenced an investigation into the death of Mohammed Ashraful Islam CHOUDHURY aged 26. The investigation concluded today, 6 January 2026, after a four day inquest hearing, with the following **Narrative Conclusion**: **The Deceased was unlawfully killed on 11 January 2023 by another resident in his supported accommodation, who suffered with paranoid schizophrenia, unusually, associated with violent behaviour; this other resident had stopped being concordant with medication from mid-September 2022 and, it was possible, that the Deceased's death was caused, in part, because the risks of this had not been appropriately addressed by mental health services.**
4	**CIRCUMSTANCES OF THE DEATH** The Deceased, under the care and treatment of his community mental health team had been residing at Biscot House since April 2022. Prior to his arrival there, on 5 February 2019, another male, also under the care and treatment of the same community mental health team, had been placed there. During his stay, this other resident had relapsed on 2 occasions in 2019 and 2020 requiring detention under the Mental Health Act, during which time, he had been diagnosed with paranoid schizophrenia, the treatment for which was medication and psychological therapy. Whilst there were periods when his psychosis was manageable, there were also times when it escalated and, unusually, was associated with violent behaviour. By the time of this resident's hospital discharge in August 2020, Biscot House had concluded that his needs had escalated since his original assessment and that he could no longer be regarded as having 'low level' support needs; although, they had been persuaded to take him back, this had been on a temporary basis only whilst a 24/7 hour supported placement was sought, along with an enhanced care package to support his concordance with medication in the meantime. However, no alternative placement for this resident was ever found and, when the Deceased moved into Biscot House, he was given the room next door to him. In May and June 2022, this resident complained to the Deputy Manager of Biscot House about the Deceased playing his music and not flushing the toilet properly. Despite being aware that this resident lacked insight into his illness and, as such was at risk of becoming non-concordant with his medication, in July 2022, the mental health team chose to cancel the care services who had been supporting him with his prescribed oral medication, without any prior checking with his GP surgery that he was still ordering and receiving his prescriptions (which he was not). On 18 September 2022, after

	this resident's GP practice had mistakenly informed him that he had been discharged from mental health services on 9 September 2022, he subsequently refused to take his depot and continued to refuse to do so thereafter. Even though it was known that his mental health would deteriorate after that point, and that such deterioration could include violent and aggressive behaviour, the measures taken by mental health services to address his non-concordance with medication were insufficient to avoid the 'real and immediate risk' that he then posed to the Deceased; appropriate safety netting measures in the form of a clear MDT plan (to include an alternative medication regime, mental health act assessment, and/or effective increased surveillance) could and should have reasonably been taken at that time. On 9 and 10 January 2023, this resident again complained about the Deceased playing music and being loud and, at 09.47 hours on 11 January 2023, he sent a text to the Deputy Manager stating: "Both flushing meconism's on the upstairs toilets are malfunctioning". Around 40 minutes afterwards, at 10.25 hours, this resident attacked and stabbed the Deceased [redacted], inflicting a single stab wound to the front left of his chest causing him an injury to his heart that was not survivable; the Deceased's death was confirmed at Luton & Dunstable Hospital at 14.10 hours that same day.
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) (i) The risks identified in respect of [redacted] on his discharge from his second hospital admission in August 2020, which included the fact that his paranoid schizophrenia (unusually) was associated with violent behaviour and that he lacked insight into his mental illness, were not adequately addressed by his mental health provider. This was of particular concern when he became non-concordant with his anti-psychotic depot medication from mid-September 2022. (ii) There was no MDT plan to address the significant development of [redacted] non-concordance with his anti-psychotic depot medication from mid-September 2022. (iii) Despite knowng that [redacted] lacked insight into his mental illness and of the need to ensure that he remained compliant with all medication, the support provided to him with medication administration, in addition to his depot, was withdrawn without there being any checks made with his GP as to whether he was remaining complaint with this medication (which he was not).
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 March 02, 2026. 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]

	[redacted] **(SIG)** I have also sent it to who may find it useful or of interest. 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	**Dated: 06/01/2026** [redacted] **Emma WHITTING** **Senior Coroner for** **Bedfordshire and Luton Coroner Service**