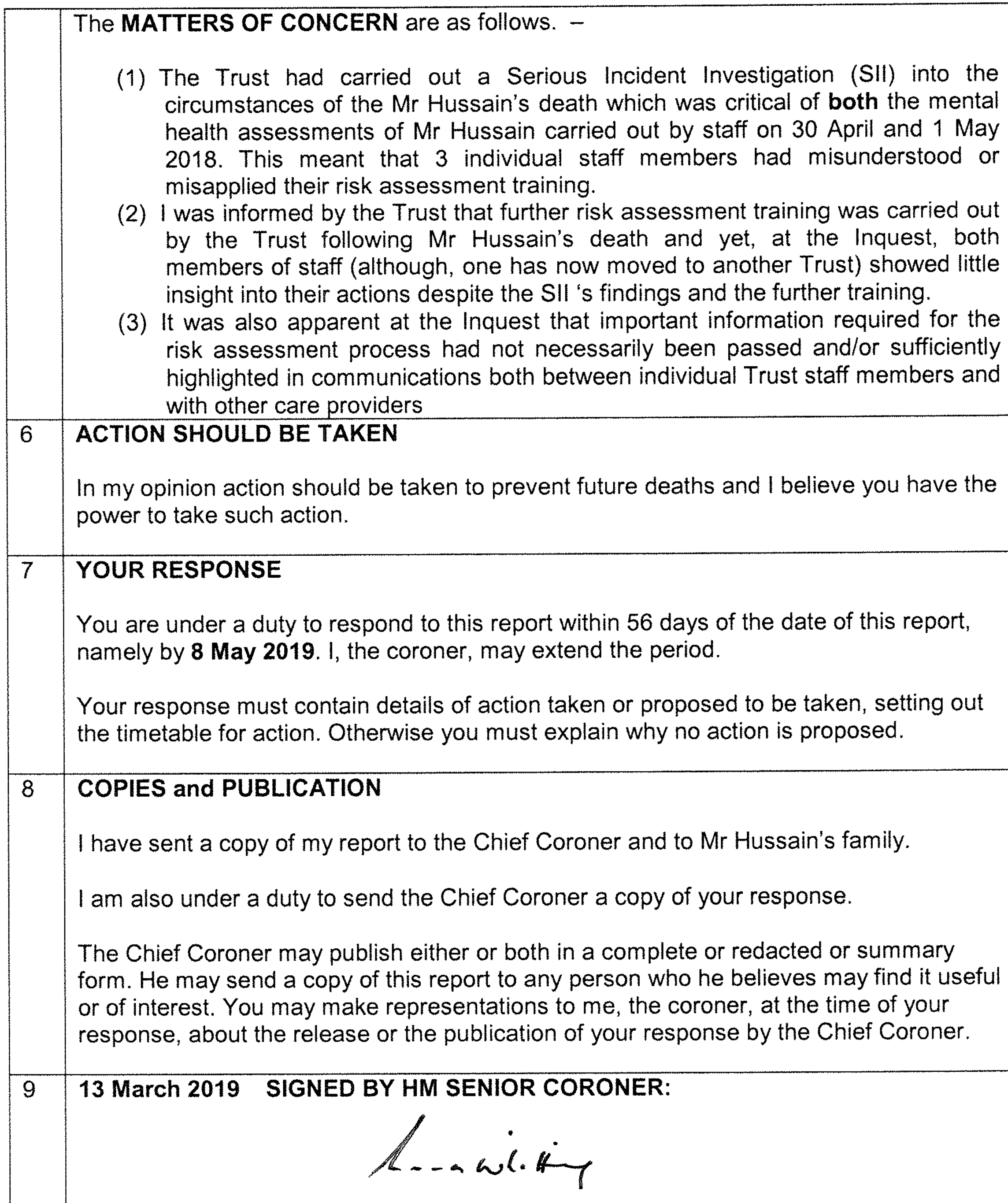
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Dr Navina Evans, Chief Executive, East London Foundation NHS Trust, Robert Dolan House, Trust Headquarters, 9 Alie St, London E1 8DE**
1	**CORONER** I am **Emma Whitting**, Senior Coroner for Bedfordshire & Luton
2	**CORONER'S 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/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 15 May 2018 the Acting Senior Coroner for Bedfordshire & Luton commenced an investigation was into the death of Mr Mohammed Hussain, aged 30. The investigation concluded at the end of the Inquest held by me on 26 February 2019 and on 7 March 2019 my determinations and conclusion were delivered. The medical cause of death was found to be: 1a Carbon Monoxide Toxicity and Extensive Burns The Conclusion of the Inquest was a Narrative Conclusion: *The Deceased took his own life, intending to do so, but whilst suffering from mental distress*
4	**CIRCUMSTANCES OF THE DEATH** The Deceased suffered a deterioration in his mental health from November 2017. On 21 December 2017, he was admitted to the Luton & Dunstable hospital following an overdose and was assessed by psychiatric services who referred him for GP review. On 28 April 2018, he took a further overdose and, on 30 April 2018, was assessed by his GP as being at high risk of suicide and was re-referred to psychiatric services. Although he was still at high risk, psychiatric services initially assessed him to be at medium risk and he was discharged for a community assessment at home the following day when his risk level was further reduced to low; apart from counselling services and medication, he was not offered any further psychiatric support. As his condition continued to deteriorate, alternative medical management may have altered subsequent events. On 12 March 2018, he drove himself to Eldon Rd, Luton, where he parked and, shortly before 18.00 hours, having soaked the interior of the car with fuel, he set fire to himself whilst sitting in the rear passenger seat. His death was confirmed by police who attended the scene at 19.00 hours.
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 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. – (1) The Trust had carried out a Serious Incident Investigation (SII) into the circumstances of the Mr Hussain's death which was critical of **both** the mental health assessments of Mr Hussain carried out by staff on 30 April and 1 May 2018. This meant that 3 individual staff members had misunderstood or misapplied their risk assessment training. (2) I was informed by the Trust that further risk assessment training was carried out by the Trust following Mr Hussain's death and yet, at the Inquest, both members of staff (although, one has now moved to another Trust) showed little insight into their actions despite the SII 's findings and the further training. (3) It was also apparent at the Inquest that important information required for the risk assessment process had not necessarily been passed and/or sufficiently highlighted in communications both between individual Trust staff members and with other care providers
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 **8 May 2019**. 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 Mr Hussain's family. 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	**13 March 2019 SIGNED BY HM SENIOR CORONER:**