	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Rt. Hon. Matthew Hancock, Secretary of State for Health & Social Care, Department of Health & Social Care 39 Victoria St, London W1H OEU
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 5 April 2018 the Acting Senior Coroner for Bedfordshire & Luton commenced an investigation was into the death of Mr Matthew Jones, aged 35. The investigation concluded at the end of the Inquest held by me, on 16 May 2019, when my determinations and conclusion were delivered. The medical cause of death was found to be: 1a Cocaine Toxicity The Conclusion of the Inquest was a Narrative Conclusion: *The Deceased's death was drug-related but his discharge from hospital to accommodation which was not supported more than minimally, negligibly or trivially contributed to it.*
4	**CIRCUMSTANCES OF THE DEATH** . *The Deceased had a diagnosis of paranoid schizophrenia and polysubstance misuse and was under the care of Probation, Community Mental Health and Drug & Alcohol Support Services. A relapse in his conditions led to him being evicted from his accommodation on 8 February 2018 and it was agreed at a Professionals Meeting on 9 February 2018 that he required supported accommodation. After subsequently suffering threats at his temporary emergency accommodation, he was admitted to Ash Ward, Oakley Court, Bedfordshire, on 20 February 2018 for further treatment. Although he remained on Ash Ward until 29 March 2018, neither the Mental Health nor the Housing Teams proactively sought supported accommodation for him and he was discharged from Ash Ward back to temporary accommodation in Luton on the afternoon of 29 March 2018. Shortly after midnight that evening, he was found behaving erratically on a street corner connecting Farley Hill with Whitehall Avenue in Luton and soon after suffered a cardiac arrest. He was taken by attending paramedics to the Luton & Dunstable Hospital but his death was confirmed there at 03.40 hours. Post-mortem*

	examination confirmed a Cocaine blood concentration of 3.0 mgΛ.
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. The evidence at the Inquest, the evidence revealed: (i) an absence of appropriate training for clinicians and healthcare workers involved in the delivery of mental health services who have responsibility for the care of persons subject to *Community Mental Health Treatment Orders* (linked to *Mental Health Treatment Requirement Care-Plans* including treatment by Drug & Alcohol Services); and, as a result, (ii) a poor appreciation, including a lack of co-ordinated and multi-agency working, by such clinicians and healthcare workers of the likely risks of non-compliance with treatment linked to *Community Mental Health Treatment Orders*, and, particularly, of the importance of ensuring that 'housing' is part of any hospital discharge planning.
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 **29 July 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 Jones' family and also to the Ministry of Justice for their information. 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	**3 June 2019 SIGNED BY HM SENIOR CORONER:**