REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **East Leicestershire Clinical Commissioning Group** **Heart of England NHS Foundation Trust** **Minister for Health (Mr Matthew Hancock)**
1	**CORONER** I am Mrs Dianne Hocking Assistant Coroner, for the area of Leicester City and Leicestershire South
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 08 December 2017 I commenced an investigation into the death of David Reginald Bert Stacey The Inquest concluded on 14 December 2018 before a jury. Cause of Death 1a) Chest injuries sustained in a road traffic collision.
4	**CIRCUMSTANCES OF THE DEATH** The findings of the jury in Box 3 were 'Mr Stacey was in his Toyota car on the A4304 Theddingworth Road at 11.02 on the 27th of November 2017, after a road traffic collision. Despite medical treatment he was pronounced dead at the scene. The road traffic collision was attributed to Mr Stacey driving at approximately 78 MPH and crossing the double solid central line into oncoming traffic.' The jury's conclusion in Box 4 was:- 'On the 27th of November 2017at 00:23 the police received a 999 call from Mr Stacey's neighbour that Mr Stacey was at his neighbours home and had allegedly been attacked. The police attended and took Mr Stacey back to his own home. Mr Stacey was agitated and worried the I.R.A were after him. The police decided that Mr Stacey needed to be seen by Triage Car to be assessed and they were called. Triage Car arrived and the senior mental health nurse spoke to Mr Stacey and decided he needed to be assessed under section 2 of the mental health act. The mental health act assessment team were contacted and the Triage Car nurse gave a handover to one of the doctors. The doctors agreed he needed to be assessed and said they would attend after they had finished their current assessment. The Triage Car team informed the police the mental health act assessment team were on their way and they could leave when the next mental health act assessment team arrived. The mental health act assessment team arrived and were given a handover by the police. We feel unanimously that the handover was appropriate. After the handover the police left and we feel unanimously that the police officers should not have remained at the property whilst the assessment was taking place. We feel unanimously that there was no further police presence needed despite the calls made. During the assessment there was concern by the mental health act assessment team, however we feel unanimously that Mr Stacey's behaviour did not warrant the mental health assessment team leaving the premises. The doctors made the recommendation that Mr Stacey should be detained under section 2 of the mental health act and the AMHP accepted their recommendations. We feel unanimously that the

	AMHP became responsible for Mr Stacey's safety. After the assessment, the mental health act assessment team decided to leave the building and Mr Stacey was left alone. We feel unanimously that the level of risk was assessed appropriately as a high level of risk. The mental health act assessment team then convened in a car outside to finish paperwork and escalated the case on to their respective line managers. Mr Stacey had no further known contact until 10-12 AM on the 27th November when a 999 call was made by him. In this call he repeatedly used the phrase "violet line", so we unanimously feel, that Mr Stacey was still suffering psychotic symptoms. Mr Stacey was then involved in a fatal road traffic collision at 11.02AM on 27th November 2017.We accept the admission by the Leicestershire Partnership Trust that a bed was available for Mr Stacey and find that it was not communicated properly due to a serious failure in their process. Additionally we find that Mr Stacey's death was "contributed to by neglect by the mental health act assessment team" due to the team leaving Mr Stacey's property before other safeguards had been put in place.
5	**CORONER'S CONCERNS** An expert was instructed to advise on the psychiatric aspect of Mr Stacey's death. One of the issues he identified was a failure to identify availability of a bed for cases of special urgency. This is a **statutory requirement** under section 140 of the Mental Health Act 1983 that the relevant health bodies (local Clinical Commissioning Group and Local Health Board) give advice to every social services authorities within the area of arrangements that are in force for the reception of mentally disordered patients in cases of special urgency. The expert was in no doubt that Mr Stacey would have fulfilled the 'special urgency' category. It transpires from my further communication with the Leicestershire Partnership Trust that there is no such facility in Leicestershire. It would appear to be a statutory requirement that is currently being ignored and I am concerned that another similar situation might arise when there are no beds available to or identifiable by, the local Trust.
I.	**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 25 February 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 the following Interested Persons:- a) [redacted] (next of kin of Mr Stacey) b) Leicestershire Partnership Trust (Chief Executive Dr P Miller and Chief Nurse [redacted]) c) Leicester City Adult Safeguarding (Pretty Patel) d) Chief Constable of Leicestershire Police e) Covea Insurance 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	**[DATE]** 28/12/18	**[SIGNED BY CORONER]**

NHS
East Leicestershire and Rutland
Clinical Commissioning Group

From the office of: Karen English, Managing Director
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25 February 2019

Mrs Dianne Hocking
Assistant Coroner
Leicester City and Leicestershire South
The Coroner's Court
Town Hall
Town Hall Square
Leicester, LE1 9BG.

Dear Mrs Hocking,

Re: Regulation 28 notice following the investigation into the death of Mr David Reginald Bert Stacey

I write in response to the Regulation 28 Notice issued to the CCG following the investigation into the death of Mr David Stacey, particularly in relation to the CCG's responsibilities under section 140 of the Mental Health Act 1983.

The CCG notes that section 140 of the Mental Health Act 1983 states the following:

> ***Notification of hospitals having arrangements for special cases.***
> *It shall be the duty of every clinical commissioning group and of every Local Health Board to give notice to every local social services authority for an area wholly or partly comprised within the area of the clinical commissioning group or Local Health Board specifying the hospital or hospitals administered by or otherwise available to the clinical commissioning group or Local Health Board in which arrangements are from time to time in force*
> *(a) for the reception of patients in cases of special urgency;*
> *(b) for the provision of accommodation or facilities designed so as to be specially suitable for patients who have not attained the age of 18 years.*

In line with the regulations the CCG has informed the local social services authorities within the CCG area that Leicestershire Partnership NHS Trust (LPT) is the mental health hospital that should be contacted for the reception of patients in cases of special urgency; and for the provision of accommodation or facilities designed so as to be specially suitable for patients who have not attained the age of 18 years. It would then be the responsibility of LPT to arrange for the specific bed type required by the sectioning doctors to be available either locally within LPT services or further afield if not available locally, which is in line with the services the CCG commissions from LPT. Furthermore, the CCG is

working proactively with LPT to ensure a "no out of area acute admission rule" forms part of the LPT contract from 1 April 2019.

I note that in this case the AMHP, from the local authority, contacted LPT in line with the local arrangements and information that the CCG has communicated to the local authority (as required under section 140 of the Mental Health Act 1983).

I hope that this information is helpful. Please do not hesitate to contact me if I can be of any further assistance.

Yours sincerely

Karen English
Managing Director