MISS N PERSAUD
HER MAJESTY'S CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Chief Executive Officer, Patient Transport UK Ltd, Unit 3, Summit Centre, Summit Road, Potters Bar, EN6 3QW** [redacted]
1	**CORONER** I am Nadia Persaud area coroner for the coroner area of East London
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/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 4th December 2019 I commenced an investigation into the death of Mr Robert Walaszkowski, age 35 years. The investigation concluded at the end of the inquest on 22nd September 2021. The conclusion reached by the jury was a narrative conclusion: *The original head and neck injury was the primary trigger that led to a series of events which ultimately caused Robert's death. Robert's neck was not cleared by paramedics nor A&E staff and this failure to identify his injury meant it was left unsupported. This led to further injury to the spinal cord and vertebral artery during the course of his care which ultimately lead to a hypoxic brain injury which contributed to his death. His death was contributed to by neglect.*
4	**CIRCUMSTANCES OF THE DEATH**

	Robert Walaszkowski sustained a head injury and cervical spine damage whilst he was a detained mental health patient at Goodmayes Hospital. The injury occurred on the 19th October 2019 after he was seen to run towards a locked door. It is likely that he collided with the door. Robert was taken to A&E. Whilst in A&E, Robert was given three doses of 4mg of lorazepam. This exceeded the Trust's guidelines. He did not undergo a cervical spine CT scan and he did not receive a full medical assessment before his discharge. In the early hours of the 20th October, Robert was discharged from Queens Hospital in a very poor state of physical health. His neck was not supported and he was transported in an unsuitable vehicle back to Goodmayes Hospital. On arrival at Goodmayes Hospital, Robert was found unresponsive on the floor of the vehicle. He was in respiratory arrest. Paramedics transferred him back to Queens Hospital where he was diagnosed with catastrophic injuries to his cervical spine, right vertebral artery and hypoxic brain injury. He passed away from these injuries on 15th November 2019 at Queens Hospital.
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: By virtue of his detention under Section 2 of the Mental Health Act, a secure transport vehicle was booked to transfer Robert back to Goodmayes Hospital. Robert was in an extremely poor state of physical health. He was unable to weight bear, unable to sit up on a wheelchair and unable to hold his head upright. Robert was placed onto the floor in the caged section of the vehicle. Robert's partner and the healthcare support worker accompanying him, raised concerns about the suitability of the vehicle. There were no seatbelts or means of securing Robert into the vehicle. On his arrival to Goodmayes Hospital, following a fifteen to twenty-minute journey, he was found unresponsive and in respiratory arrest. The independent expert stated that Robert's airway was unlikely to have been protected in the position in which he was transferred and this is likely to have contributed to the respiratory arrest. The inquest heard evidence that this was not a one-off occurrence, but that there is a practice whereby detained mental health patients are placed on the floor of secure vans. It is of concern that: (i) There was no review by Patient Transport UK Ltd into the service provided to Robert in the early hours of 20 October 2019. (ii) The apparently trained transport staff did not re-consider the appropriateness of the vehicle when they observed Robert's very low level of consciousness and his inability to walk; sit unaided and hold his head upright. (iii) The staff placed Robert, in this concerning condition, on the floor of the vehicle without any seat belt or other mechanism to keep him safe and secure. (iv) Placing mental health patients on the floor of the caged area, seems to be an accepted practice by Patient Transport UK Ltd.
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 **25d November 2021**. 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 the family of Robert Walaszkowski, the LAS, the A&E Consultant, North East London Foundation Trust and Barking, Havering & Redbridge University Hospitals NHS Trust. I have also sent it to the CQC and the local Director of Public Health 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 to all interested persons who in my opinion should receive it. I may also send a copy of your response to any other 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.
9	**30 September 2021**