[redacted]

Senior Coroner - Emma Whitting
Bedfordshire & Luton
REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: [redacted], Chief Executive, Association of Directors of Adult Social Services [redacted], Chief Executive, Royal College of Psychiatrists Sajid Javid, Secretary of State for Health and Social Care [redacted], Chief Executive East London NHS Foundation Trust [redacted], Director of Social Care, Health and Housing, Central Bedfordshire
1	**CORONER** I am Dr Séan Cummings, Assistant Coroner for the area of the 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. 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 Seventh February 2019 I commenced an Investigation into the death of James EMMERSON aged 23. The investigation concluded at the end of the inquest on Fourteenth April 2021. The conclusion of the inquest was Narrative Conclusion - Jamie Emmerson died at his home address on the 3rd February 2019 after [redacted] Ib Ic II
4	**CIRCUMSTANCES OF THE DEATH** James Emmerson, known as Jamie to friends and family was a young man with complex mental health issues. He had been viciously assaulted as an adolescent resulting in post traumatic stress disorder and also was diagnosed with emotionally unstable personality disorder. The combination meant that he found difficulty in establishing lasting relationships including with mental health professionals. That in turn meant that when he did present they were acute crisis presentations. He was detained under s 136 of the Mental Health Act on the 1st February 2019 at the Luton and Dunstable Hospital Section 136 suite on Jade Ward. The Mental Health Act s 136 is clear as to the procedure to be followed. It was not followed and Jamie was not seen by an Approved

	Mental Health Professional before his section 136 detention was discharged. The reason for this was an erroneous reliance on an ambiguity in the Code of Practice: Mental Health Act 1983 (section 16:50). He was discharged and as a result of an assault on police officers, was detained at the Luton Police Custody Suite and after interview and charge was released as required. He died on the 3rd February by hanging. I could not satisfy myself, on the balance of probabilities after hearing all the evidence that he intended suicide. His life was characterised by impetuous actions from which I formed the view that he believed he would be rescued. I believe he misjudged events on this final occasion.
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 will 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. **Confusion generated by the Department of Health Guide "Mental Health Act 1983 Code of Practice" ("The Code").** The Mental Health Act 1983 is the relevant Act under which persons may be assessed or detained when they are suspected or diagnosed as having one of a number of mental disorders. Section 136 of the Mental Health Act 1983 is a power which allows police officers to remove a person who is in a place to which the public have access to a place of safety. Many mental health facilities have designated "section 136 suites" where the detained person can be taken for assessment. Jamie was in a public place when his psychiatric needs assessed by police were such that he needed to be taken to a place of safety. He was taken to the section 136 suite at the Luton and Dunstable University Hospital. Section 136 (2) MHA 1983 provides that *"A person removed to or kept at a place of safety under this section may be detained there for ……. the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an approved mental health professional and of making any necessary arrangements for his treatment or care".* "The Code" (s 16.25) states: *"The purpose of removing a person to a place of safety in these circumstances is **only** to enable the person to be examined by a doctor **and** interviewed by an AMHP, so that the necessary arrangements can be made for the person's care and treatment.* "The Code" (s16.27) states: "*The person should be **assessed** by a doctor and interviewed **by an AMHP** as soon as possible after the person is brought to the place of safety.*" Jamie was never examined by an AMPH only by a lone section 12 approved

junior doctor and he was discharged from his s.136.

In answer to the question as to why he was not examined by an AMPH s 16.50 of "The Code" was relied on which states: *"If a doctor assesses the person and concludes that the person is not suffering from a mental disorder then the person must be discharged,* ***even if not seen by an AMHP****."*

This was interpreted as meaning that assessment by an AMPH was not a required formality. This was a deeply flawed interpretation but it is possible to see where the ambiguity arises.

I was told that this arrangement was "custom and practice" in Bedfordshire and Luton and also in other areas. Whether it was custom and practice or not I consider that the arrangement contravened both the spirit and the letter of the Mental Health Act 1983. It exposed patients to significant risk, including that of self harm or suicide by failing to provide adequate assessment prior to discharge from s. 136 detention. I was told that the position in Bedfordshire and Luton had been regularised by the time of the Inquest but I have no knowledge as to practice in the "other areas" referred to.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you: [redacted], Chief Executive, Association of Directors of Adult Social Services [redacted], Chief Executive, Royal College of Psychiatrists [redacted], Secretary of State for Health and Social Care 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 02 March 2022. 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 [1] [redacted], Jamie's mother [2] [redacted], Chief Constable, Bedfordshire Police [3] [redacted], Director of Social Care, Health and Housing, Central Bedfordshire Council [4] [redacted], Chief Executive, East London NHS Foundation Trust. 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	Dr Séan Cummings Assistant Coroner Bedfordshire and Luton Coroner Service 5th January 2022