Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Chief Executive ELFT -** [redacted] **2 NHS England & NHS Improvement** [redacted]
1	**CORONER** I am Emma WHITTING, Senior Coroner for the coroner area of 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.
3	**INVESTIGATION and INQUEST** On 10 June 2020 I commenced an investigation into the death of Luke Richard WILDEN aged 18. The investigation concluded at the end of the inquest on 20 July 2021. The conclusion of the inquest was that: *The Deceased, who had a diagnosis of high functioning Autism and ADHD, had been in the care of social services and living in supported accommodation from the age of 15. After turning 18, there was a failure to transition him effectively from Child & Adolescent to Adult Mental Health Services and there was no assessment of his needs to enable provision of an appropriate adult social care package, including suitable accommodation. Instead, on 2 January 2020, he moved to independent living in a flat in Bedford, after which his mental health declined and he became subject to cuckooing and alcohol and drug misuse. Despite several psychiatric admissions from early February 2020 and growing concerns about his ability to keep himself safe whilst living independently, there was a continued failure by mental health services to carry out a needs assessment for him. Although he was re-admitted by the Crisis Team to in-patient psychiatric services (Crystal Ward) in the early hours of 19 May 2020, after being found unconscious in London following a Spice overdose, and the Ward had the ability to detain him to allow alternative living arrangements to be made, he was again discharged back to his Bedford flat in the afternoon of 20 May 2020. Following this discharge, he immediately met up with a known drug user whom had been cuckooing him previously. After being uncontactable from the morning of 21 May 2020, he was found deceased in his flat at around 11.20 hours on 22 May 2020; his death being confirmed by attending paramedics at 12.20 hours. Post-mortem examination revealed evidence of cardio-toxicity arising from cocaine and heroin use.*
4	**CIRCUMSTANCES OF THE DEATH** *The Deceased was a vulnerable adult who had not been transitioned effectively from Child & Adolescent to Adult Mental Health services on reaching the age of 18. The consequence of this, together with the repeated systemic failure of mental health services to assess his needs, resulted in him living in unsuitable accommodation with inappropriate support from 2 January 2020 which placed him at risk of harmful activity, including drug use. Although there was no determination of civil liability, this previously identified failure as well as the failure to detain him during his final in-patient admission amounted to his death being contributed to by neglect on the part of mental health services.*

5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: **Transition arrangements within ELFT for individuals with high functioning autism were inadequate when Luke turned 18 and, as a result, he was not transferred to the appropriate adult mental health team for continued treatment and to enable provision of an appropriate adult social care package, including suitable accommodation for him. Whilst I understand that changes have been made within ELFT in order to address this gap in services, I am concerned that these may still not be sufficient. Furthermore, I am concerned that this gap in services may also exist on a national level.**
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 March 13, 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: [redacted] I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any 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 by the Chief Coroner.
9	**Dated: 16/01/2022** **Emma WHITTING** **Senior Coroner for** **Bedfordshire and Luton Coroner Service**