West London Coroner Service
25 Bagleys Lane, Fulham, London, SW6 2QA

Date: 7 March 2024

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: , Director of Safety

Central and North West London NHS Foundation Trust

350 Euston Road

Regent's Place

London NW1 3AX

1 **CORONER**

I am **Richard Furniss, Assistant Coroner at West 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 **INQUEST**

I conducted an Inquest into the death of David Louis SIIRAK between 4 and 7 March 2024. Mr Siirak was a detained inpatient in Frays Ward in the Riverside Centre. On 1 March 2020, he was the victim of a serious assault at the hands of another patient in his room on the Ward, as a result of which he suffered unsurvivable injuries which caused his death on 4 March 2020.

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. Mr Siirak was discovered in his room, having been assaulted, at 1647 hours on 1 March 2020. The crash team, led by [redacted], arrived at 1703 hours. The evidence was that between those times (until [redacted] took charge at 1703) the response of ward staff to the incident was "chaotic" and "panicking" (as was acknowledged by the staff).

The evidence was that various members of your staff had never previously been involved in a real or simulated emergency. By "simulated emergency", I mean an unexpected dummy run on the ward, as opposed to training in the calm confines of a planned day.

One member of staff told the court that she had never been involved in an unexpected simulated emergency in the 14 years of working on the ward prior to 1 March 2020, nor in the 4 years since.

The jury found that "there was a clear failure to provide the adequate training in simulation exercises to effectively manage situations like the one that occurred on 1st March 2020."

It was equally clear on the evidence that members of staff have still not undergone unexpected simulation training.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, Mr Pooler, 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 Monday 6 May 2024. I as 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] (father of the Deceased) and [redacted] (sister of the Deceased) by their solicitors Messrs Hodge Jones & Allen. 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.
	8 March 2024
9	Signature Richard Furniss, Assistant Coroner for West London