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Cumbria, Northumberland,
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NHS Foundation Trust

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Derek Winter
HM Senior Coroner for Sunderland
The Coroner's Office Civic Centre
Burdon Rd
Sunderland
SR2 7DN

Dear Sir

Inquest into the death of Daniel Futers
Regulation 28 Report to Prevent Future Deaths Response

We write in response to your Regulation 28 Report dated 2 February 2023 following your investigation into the death of Daniel Futers.

The Trust was extremely disappointed to receive this Regulation 28 Report. As HM Coroner is aware, the Trust takes all patient deaths very seriously and investigates them rigorously to establish if lessons can be learned or services can be improved and this case was no exception. It is noted however, that this investigation did not identify any issues with the care provided to Daniel and/or any issues in relation to compliance with Trust policies/procedures, save for in relation to an issue identified whereby Daniel's belongings went missing whilst he was on leave. Following receipt of the Inquest outcome, the Trust has carried out a further review of the serious incident investigation report findings and has not identified any omissions of key evidence or additional learning points.

For the purposes of responding to your specific concerns raised in the Regulation 28 Report, I shall address each of them in turn:

1. **The recording of information, particularly that conveyed, was not as comprehensive as it ought to have been. For example, a record of an altercation had not been made.**

   As presented at the inquest:-

   a. The expectation of the Trust is that all contact with a patient and/or carer/family member is documented in the patient's electronic care records. There is no reason to believe that this did not occur in this matter and HM Coroner did not hear any evidence from the Trust that there were any

issues in the recording and documenting of information provided to those involved in Daniel's care.

b. A number of contacts were made by Daniel and/or his mum to the ward between 29 March and 3 April 2022 advising that Daniel was 'bored' and / or 'anxious'. Assurances and advice was provided by ward staff on each occasion as well as consultation with the on-call Consultant where appropriate. In this period, Daniel was also reviewed by [redacted] on 30 March 2022 and again by 3 members of nursing staff when his depot medication was administered on 2 April 2022. All of the above contacts were documented in Daniel's progress notes including documentation to confirm that the above concerns had been reviewed appropriately by the on-call Consultant.

c. No concerns were raised by Daniel's family or Daniel on either 4 or 5 April 2022. However, it is noted in the statement submitted by Daniel's mum that she had a number of concerns over and above Daniel being anxious and bored whilst he was on leave including him *'standing guard*' over her while she was sleeping, asking about *'fast forwarding his life*', talking about government conspiracies and Daniel generally displaying paranoid behaviour. It is also noted in this statement however, that Daniel's mum '*did not have much communication with staff but had written an extensive list of…concerns…which I intended to raise whilst we were there and face to face…*' Had this information been fed back to the Ward, the clinicians could have reviewed and acted upon the information appropriately. It is therefore entirely unfair and disproportionate to criticise the Trust for its recording of information, or alleged lack thereof, when such information was not reported.

d. In respect of the altercation referred to by Daniel's mum in which it is alleged that Daniel broke his phone whilst on the ward, the entry in the progress notes from 29 March 2022 is detailed and, most importantly, contemporaneous. That it does not accord with Daniel's mum's recollection of the call as expressed during the inquest is not in itself a reflection of a fundamental issue with Trust recording of notes.

2. **Comprehensive planning for home leave and discharge from hospital was not evident, including contingency planning and the involvement of the family.**

The evidence at the inquest confirmed the following: -

a) Daniel was acutely unwell when he arrived at Hopewood Park hospital on 22 February 2022 and was detained under s.2 MHA however, he made a 'remarkable' (but not unusual) recovery once his depot medication had been commenced. This was entirely in line with his previous pattern ('nature' with

reference to the terminology of the MHA) of recovery and it was clinically appropriate for professionals to rely on previous history as an indicator of how Daniel's illness may progress.

b) Daniel was assessed on 22 March 2022 by [redacted] and a Nurse practitioner and it was felt that Daniel had considerably improved and was insightful as to the need for treatment. The plan following this assessment was to continue with his depot medication and to trial section.17 leave starting with escorted leave.

c) S.17 leave was part of Daniel's treatment plan and the intention was to progress leave gradually i.e. starting with escorted leave for a short period of time and leading up to an extended period of unescorted leave. This is in line with expected practice and was appropriate in terms of balancing risks, clinical need and testing the response to treatment in order to safely work towards discharge.

d) The intention of s.17 leave is to provide patients with independence to manage in the community and to avoid patients becoming institutionalised and/or reliant on mental health services. In the vast majority of cases, it will be a fundamental part of the treatment plan. Daniel was no exception to this.

e) [redacted] confirmed that Daniel was asked during every assessment whether he had any stressors and he denied this at each assessment. Dr Chan confirmed that Daniel was looking forward to the future, getting back to work and the gym and building a life in the community. In addition to what Daniel was verbally reporting, [redacted] was assured objectively by Daniel's presentation, demeanour and reported observations of him on the ward and assured that he was recovering.

f) [redacted] considered that Daniel's leave was going well and although he was aware of reports regarding 'boredom' and some 'anxiety', there were no concerns highlighted either subjectively or objectively which would have warranted Daniel to be recalled to hospital.

g) Daniel had been assessed as low risk of self-harm and it appeared that he only self-harmed when he was acutely unwell (with the last known self-harm / suicide attempt having been in 2014 immediately prior to a hospital admission). Daniel was not acutely unwell at the time the leave was authorised. [redacted] confirmed that the fact that Daniel had been so responsive to the depot medication was a protective factor whilst he was on leave. [redacted] confirmed that Daniel's further protective factors were future planning, his family and a community treatment plan (whereby Daniel's depot would be administered by the Community Treatment Team).

h) [redacted] confirmed that the key risk factor for Daniel in the community was illicit drug use although Daniel confirmed that he had not recently being taking

illicit drugs.

i) [redacted] confirmed that Daniel had had previous admissions to hospital whereby Daniel had only been admitted for a short period of time prior to being discharged from his section.

j) [redacted] advised that boredom in itself would not be a reason to recall a patient to hospital.

k) [redacted] confirmed that s.17 leave would be reconsidered by the MDT on a daily basis and indeed it was in this case.

In light of the above, the Trust considers that there had been comprehensive multi-disciplinary consideration of Daniel's case prior to his s.17 leave being granted which was in line with the Trust policy/procedure in respect of s.17 leave. [redacted] explained in his evidence that once Daniel had started to respond to treatment, his leave had been progressed gradually as part of his care and treatment plan alongside his depot medication. [redacted] confirmed that there was no reason to suggest that the plan in place was not appropriate and that both Daniel's subjective and objective presentation were considered in reaching this decision. To the extent that there had been any discrepancy between the objective and subjective presentation, [redacted] confirmed that the decision to grant leave would have been reconsidered accordingly.

In respect of contingency planning, Daniel was still detained under s.3 of the Mental Health Act at the time of his death and could have been recalled to hospital in the event that there were any significant concerns raised in respect of his mental health whilst on leave. The Trust does not accept that any significant concerns were raised which should have triggered this recall and no such evidence was presented at the inquest hearing. Furthermore, Daniel had agreed to engage with treatment in the community and did in fact return to the Shoredrift Ward for his depot medication on 2 April 2022. During this appointment, a mental state examination was carried out and no issues were raised by Daniel and/or the staff performing this examination (which included 3 members of nursing staff including a clinical lead on the Ward).

3. **Overall situational awareness about Daniel was not evidenced, including the reconciliation of conflicting accounts about him.**

HM Coroner is referred to the response provided above in respect of the reconciliation of alleged conflicting accounts about Daniel's presentation. On the basis of the live evidence heard during the inquest hearing and the conversations/reviews by clinicians documented in Daniel's medical records, there were no apparent conflicting accounts of Daniel's mental health and presentation during his s.17 leave. As set out above, it is accepted that Daniel's mum reported him as being bored and anxious during the leave. It was clear from the evidence of the Trust and the family that no additional concerns had been reported in respect of Daniel's leave. We therefore cannot see that there were any

conflicting accounts of Daniel's presentation to be resolved.

By way of context and background, where a patient does come to harm after a risk assessment has been carried out and a safety plan put in place, examination of those circumstances can reveal one of three reasons as to why the incident has occurred:

a. The risk assessment and associated plan may not have been sufficient robust. This is the outcome where the Trust endeavours to have the most impact by continual learning, training and practice improvement. Whilst this is identified as an issue in some incidents that we investigate, it was not the case here.

b. The risk assessment and associated plan is appropriate to the known circumstances however an individual has not disclosed their true thoughts and intentions in the course of the assessment. The Trust trains its clinicians to mitigate against this risk in so far as is possible but there are limitations to what can practically be achieved and the subjective element of risk assessment cannot be eliminated completely. The risk assessments in this case take into account subjective and objective presentation, and collateral information from the family during the leave period. As set out above no issues were identified in the in depth review of this case that suggested a lack of clinical curiosity when considering Daniel's presentation and treatment plan.

c. The risk assessment and associated plan is appropriate, the clinician and patient have a full and open discussion about risk and then between the point of the assessment and the incident, something changes to escalate risk that the clinician could not be aware of or have foreseen. Again, there are limits to the extent to which this can be mitigated against, however contingency planning to reduce the risk of a repeat self-harm attempt is specifically covered in the updated Trust training materials. Contingency and safety planning was evident in this case.

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The Trust's position following its own investigation and on review of the evidence given in the proceedings is that this incident falls into the last category. The plan was appropriate to the circumstances that were known to the Trust at the time.

Response

We hope that the information provided offers you the necessary assurances that the Trust already have in place appropriate systems and safeguards to mitigate the risks to patients whilst on s.17 leave. The Trust's policy and associated guidance (attached for your information) is based on the principles of current good practice and encourages staff members to exercise their clinical judgement when considering patient leave as part of a patient's therapeutic care regime and the management of associated issues whilst the patient is on leave. As stated in the response above, there is no reason to suggest that this Policy was not followed in this case and/or that

the Policy is not fit for purpose. Daniel's care and treatment was considered appropriately by the professionals involved in his care regularly and all decisions were made by the multi-disciplinary team.

In respect of communication with carers/family members, this is a matter which the Trust takes very seriously and acknowledges is an important part of patient care and treatment. The Trust is continuously driving improvement in this area by way of the dissemination of lessons learned, training and continuous audit.

We also hope that the above demonstrates that the Trust has invested time, effort and resource into investigating the issues you have highlighted with a view to improving patient care and safety and reducing the risk of any adverse incidents or outcome in the future. We often find it helpful to engage with Coroners in the local area to discuss any issues or concerns and would welcome a further conversation with you regarding this matter, should you find it useful to do so.

Finally, the Trust wishes to acknowledge the tragedy that the loss of Daniel's life represents for his family and friends. Nothing within this response is intended to undermine that acknowledgement.

Yours Faithfully

[redacted]

[redacted]
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[redacted] [redacted]