## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. [redacted] - Chief Executive of Tees, Esk and Wear Valley NHS Foundation Trust**<br>**2. Care Quality Commission.** |
| 1 | **CORONER**<br><br>I am Janine Richards, assistant coroner, for the coroner area of Durham and Darlington. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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. [HYPERLINKS] |
| 3 | **INVESTIGATION and INQUEST**<br><br>On the 16th May 2022 an investigation was commenced into the death of Kenneth Rippon, aged 47 years. The investigation concluded at the end of the inquest on 18th July 2023. The conclusion of the inquest was that Kenneth died on the 5th of May 2022 when he jumped or fell from the viaduct at Durham Train station, sustaining fatal injuries.The medical cause of death was multiple injuries. I recorded a narrative conclusion which included my finding that mental health services inadequate response to escalating risks, which were known or ought to have been known, including the failure to include family in assessment and safety/discharge planning contributed, more than minimally, to the death. |

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| 4 | **CIRCUMSTANCES OF THE DEATH**<br>The deceased had a history of mental health difficulties and he, and his family, had been actively seeking professional help for a significant deterioration in his mental heath in the days leading up to his death. These difficulties included self harm and suicidal ideation, as a result of command auditory hallucinations.<br><br>On the 2nd of May 2022 the deceased presented at hospital via ambulance with a mental health crisis and suicidal ideation, [redacted] He was clear that what would help him would be "to not go home" and that he did not feel safe at home. He was discharged in the absence of any comprehensive assessment, and in the absence of liaison with his family. The clinician assessing him did not have all of the important information to be able to carry out a comprehensive risk assessment, including in relation to recent incidents of self harm.<br><br>The deceased was seen by his care co ordinator on the 3rd of May 2022. The deceased again confirmed that he had drunk bleach on the command of voices, and both he and family were asking for admission. There was no comprehensive assessment. Again the clinician was not aware of important information which should have been taken into account in any assessment of risk, including in relation to self harm.<br><br>On the 4th of May 2022 the deceased presented at hospital via ambulance [redacted]. He told Doctors in the Emergency Department he had done this at the command of voices, that he still felt suicidal, and if discharged he would attempt to take his life again. There was no comprehensive assessment by mental health services and the clinician was not in possession of all relevant information as to risk. The deceased was discharged on the basis that there was no indication of current suicidal ideation at the point of the assessment or objective evidence of psychosis, to his home address, where he had indicated he did not feel safe. Whilst awaiting transport the deceased left the hospital having discarded his mobile phone and was reported missing. He was assessed as medium risk by the Police in the light of information provided by mental health services which had not been updated and did not include all risk events.<br><br>Having left the hospital, the deceased fell or jumped [redacted] on the 5th May 2023, despite the efforts of Police officers on the scene. Kenneth's intention cannot be established although it is known that the deceased was suffering from a deterioration in his mental health in the days leading up to his death, including evidence of auditory command hallucinations to harm himself.<br><br>Mental health services involved with the deceased, did not carry out comprehensive mental state assessments despite the escalating risks which were known or ought to have been known, and did not fully involve family members in care, safety and discharge planning, who were crucial to his safety. |

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| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) The serious incident investigation report in this case was not available in this case until the 24.03.2023, over 10 months since the death and around 8 months outside the NHS framework guidance of 60 days for the completion of such, despite repeated requests and a schedule 5 notice being issued to attempt to obtain a copy of the draft report to inform this investigation, which was not complied with.<br>(2) The NHS framework sets out clearly a timescale of 60 working days for the completion of investigation reports and highlights the importance of working in an open, honest and transparent way. One of the key underpinning principles in the management of all serious incidents is that they should be timely and responsive. The purpose of the investigation is to ensure that weaknesses in a system or process are identified to understand what went wrong, how it went wrong and what can be done to prevent similar incidents occurring again.<br>(3) The delay in the investigation in this case is particularly concerning in a number of respects, not least in that it revealed problems in clinical record keeping, risk assessments and the consideration of hospital admission, lack of family/carer involvement, lack of comprehensive mental state examination/assessment including capacity, safeguarding and social needs and medication review and access to services.<br>(4) As a result of the delay in the serious incident Investigation and formulation of an action plan, many of the the identified actions required to remedy these difficulties were still being actioned /completed relatively recently.<br>(5) Further one of the actions upon identification of a serious incident is to obtain, secure and preserve all relevant evidence. In this case the memory capture forms identified as being required in the immediate aftermath of the incident were not taken promptly and were seemingly only taken after I requested sight of them, several months after the incident and therefore when memories had already begun to fade. This was concerning given the identified problem of clinical record keeping at the time of these events.<br>(6) I am concerned that the extensive and continuing delays in investigating serious incidents may lead to further deaths, as lessons cannot be learnt and improvements made in a timely manner. I am also concerned that the quality of such investigations is compromised by the failure to complete memory capture forms and the passage of time before important evidence is secured. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 13th September 2023. I, the coroner, may extend the period.<br><br>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. |

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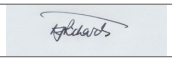
| 8 | **COPIES and PUBLICATION**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons, [redacted].<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>The Chief Coroner may publish either or both in a complete or redacted 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 | **19th July 2023**  |