REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (2)

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REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

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1. [redacted],
Chief Executive
Tees Esk and Wear Valleys NHS Foundation Trust
West Park Hospital
Edward Pease Way
Darlington
DL2 2TS

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And copied to Interested persons and to

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2. [redacted]
National Director of Patient Safety
NHS England
Wellington House,
133-135 Waterloo Road, London, SE1 8UG

And :

[redacted]

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3. CQC

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CORONER

I am Jeremy Chipperfield, senior coroner for the coroner area of County Durham and Darlington

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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.

https://www.legislation.gov.uk/ukpga/2009/25/schedule/5

https://www.legislation.gov.uk/uksi/2013/1629/contents/made

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INVESTIGATION

On 7th March 2023 I commenced an investigation into the death of Ian Darwin, 42. The investigation has not yet concluded and the inquest has not yet been heard.

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CIRCUMSTANCES OF THE DEATH

Death was caused by multiple injuries, Ian Darwin being found below [redacted] [redacted], Durham.

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5	**CORONER'S CONCERNS**

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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. –

Tees Esk and Wear Valleys NHS Foundation Trust ("TEWV") routinely fails, to employ, in a timely way, nationally recognised process and procedure designed to prevent avoidable death. In permitting delay of "serious incident" investigations, TEWV may: (i) permit lethal hazard to persist for longer than necessary; and (ii) compromise the quality of such investigations and hence their value in preventing avoidable deaths.

The above-mentioned inquest has not been heard; there has been no finding that the present death was attributable to acts or omissions in care.

Although arising in the present investigation, the matter of concern is general and has arisen in the context of other investigations. Despite past assurances that the material circumstances have been addressed, the facts of the present case demonstrate that they continue to exist. I am aware that on 19th July 2023, Assistant Coroner Janine Richards notified you of the same concern arising from matters revealed by another investigation.

TEWV identified Ian Darwin's death as a "serious incident" ("SI") for the purposes of *The Serious Incident Framework*[1] ("the Framework"). The SI investigation ("SII") process- defined in the Framework- was the means employed by TEWV to investigate this SI.

The Framework defines SIs as "events where the potential for learning is so great, or the consequences to patients… so significant that they warrant particular attention to ensure these incidents… are investigated thoroughly… and trigger actions that will prevent them from happening again". SIs "include acts or omissions in care that result in… avoidable death…". Further, the "occurrence of a serious incident **demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death** or serious harm". SI investigations are the means "to ensure that weaknesses in a system are identified, to understand what went wrong … and what can be done to prevent similar incidents happening again".

Discussing one of the seven key principles of the SI Investigation- that they be *Timely and Responsive*- the Framework requires that SIs "must be reported without delay and no longer than 2 working days after the incident is identified". One of "two key operational changes" introduced in the 2015 update was a single timeframe of 60 working days (from date of initial report) for completion of investigation reports. At an "early meeting" the investigator must "set out a realistic and achievable timescales and outcomes".

The present case:

- Death occurred on 06.03.23;
- I am informed that an investigator was initially appointed in around mid-June 2023;
- By late June, TEWV were "unable to say" when the investigation would be complete;
- The investigation is now expected to be complete in the week commencing

[1] *Serious Incident Framework,* NHS England, first published in 2010 (last updated in 2015)

	21.08.23 and its report to be finalised 18.09.23 **The general situation:** • TEWV SI death investigations, at all levels of seriousness, are routinely (if not invariably) significantly delayed and I understand there is no expectation of immediate, or any timetable for eventual rectification; • In some other cases delay is significantly longer than in the present; • Such delays affect cases of all levels of seriousness.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you 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 11 October 2023. 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 Interested Persons. I have also sent it to NHS England and the CQC, who may find it useful or of interest. 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	**15th August 2023** JS Clappenfield