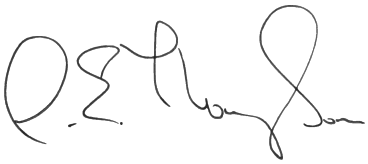
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted], Chief Executive, Tees Esk and Wear Valleys, NHS Foundation Trust**
1	**CORONER** I am James E THOMPSON, Assistant Coroner for the coroner area of County Durham and Darlington
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 29/07/2021 10:54an investigation was commenced into the death of Nicholas James STOUT 31/08/1985 00:00:00. The investigation concluded at the end of the inquest on 09/06/2023 00:00. The conclusion of the inquest was that Nicholas 'Nicky' Stout died on 26th July 2021 at Darlington Memorial Hospital due to acute cocaine toxicity and contributed to by coronary artery atheroma. Nicky had mental health issues and was recieving professional support. Nicky was diagnosed with cocaine dependency in 2015. On 26th July 2021 he consumed a large quantity of cocaine. Following symptoms of chest pains his behaviour became increasingly erratic, consistent with acute behavioural disturbance. Despite appropriate interventions from the police and ambulance services, Nicky went into cardiac arrest and subsequently died..
4	**CIRCUMSTANCES OF THE DEATH** Nicholas 'Nicky' Stout died on 26th July 2021 at Darlington Memorial Hospital due to acute cocaine toxicity and contributed to by coronary artery atheroma. Nicky had mental health issues and was recieving professional support. Nicky was diagnosed with cocaine dependency in 2015. On 26th July 2021 he consumed a large quantity of cocaine. Following symptoms of chest pains his behaviour became increasingly erratic, consistent with acute behavioural disturbance. Despite appropriate interventions from the police and ambulance services, Nicky went into cardiac arrest and subsequently died.
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: (brief summary of matters of concern) 1. The nationally set time from initial contact with the Crisis Team to some form of assessment is 4 hours. I heard evidence that achievement of this target in every case is not realised. It is of concern that timely assessment and treatment of person undergoing mental health crisis should be assessed as speedily as possible and within the set time period.

	2. The Triage Tool was explained in evidence to be essential in ensuring the patient received the correct treatment/service and is to be undertaken every time a patient contacts the Crisis Team. I was informed there was an aspiration to achieve completion of the Triage Tool every time, but it is not being completed on every occasion. It is of concern that such a key document which identifies risk, care and other matters is not completed on every occasion as it is mandated to be done. 3. In relation to making safeguarding referrals for children, the evidence I heard was in this particular case a referral should have been made and was not. I was told training had been undertaken to make all staff aware of what action to take. However, I was told in the majority of occasions it was believed a referral would be made. It is of concern in terms of protecting children that I was not satisfied that a referral was made in all situations that warranted such a referral. 4. I was told in evidence that a Safety Plan which is complied with input from the patient, their families and practitioners did not exist in Mr STOUT's case. I was told it is crucial document for identifying risks and ways to mitigate them. I was also told work was commenced by your organisation in December 2020 to ensure full and complete compliance with this requirement, but I was not reassured there was such compliance with the completion of Safety Plans in all cases at this time.
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 August 10, 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 following Interested Persons [redacted] [redacted] [redacted]**, Chief Executive, North East Ambulance Service, NHS Foundation Trust** [redacted]**, Chief Constable, Durham Constabulary** I have also sent it to **Care Quality Commission** who may find it useful or of interest. 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: 15/06/2023**  **James E THOMPSON** **Assistant Coroner for** **County Durham and Darlington**