REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (2)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Chief Executive, Tees, Esk and Wear Valleys NHS Foundation Trust, West Park Hospital, Edward Pease Way, Darlington, DL2 2TS** **2. Care Quality Commission [redacted]**
1	**CORONER** I am Janine Richards, assistant coroner, for the coroner area of 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. [HYPERLINKS]
3	**INVESTIGATION** On 25th of July 2022 an investigation was commenced into the death of Sarah Elizabeth Holmes, aged 32. The investigation has not yet concluded and the Inquest has not been heard, and is currently listed to commence on the 16th of November 2023.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a history of mental health difficulties and self harm and was found dead after a discharge home, subsequent to a mental health assessment, [redacted]. The medical cause of death is [redacted] Asphyxia

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. –

(1) The serious incident investigation by the Trust has been substantially delayed. Sarah died on the 10th of July 2022 and the Trust confirmed to the Coroner's service that there was to be a serious incident investigation on the 26th July 2022. The serious incident investigation remained unallocated and with no timeframe for completion for over 7 months and on the 13th of March 2023 as this remained the position I listed this case for Inquest on the 24th of April 2023. On the 17th April 2023 I was alerted by deceased's family to possible progress in respect of the serious incident investigation in this case, subsequent to their formal complaint to the Trust. After making enquiries of the Trust I was informed that the report would be available at the end of May 2023 and I therefore acceded to a family request to adjourn the final hearing given the short delay this would cause. On the 25th of April 2023 the Coronial service was informed that in fact that it was unlikely that the report would be finalised by May and would be' likely end of July/August time'. On the 26th of June I was informed that the report would now not be available until the 'end of September/beginning of October' and that the initial dates given were "too ambitious". The case was listed to commence on the 16th of November 2023 on that basis. On the 28th of July the deceased's family notified me of a likely further delay in the report being available due to the author's sick leave from work. The Trust offered reassurance that the report remained due 'end of September/beginning of October'. On the 28th of September a Pre Inquest Review Hearing was held in relation to a separate discrete issue and I was informed that the report was to be further delayed and would not be available until the end of October.

(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.

(3) If the final version report is received by the end of October it will be some 15 months since Sarah's death and some 13 months outside the NHS framework. This is neither timely nor responsive.

(4) I have previously issued a PFD report in relation to this issue as has the Senior Coroner for Durham and Darlington, Mr Chipperfield, who stated that Tees Esk and Wear Valleys NHS Foundation Trust 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.

(5) I am concerned that these dangers persist, despite the Trust's response to previous PFD reports and their assurances that remedial action was being taken to eradicate the delays, and as a result it is my statutory duty to make this further report.

6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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 6th of December 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], Sarah's parents. 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	**11.10.23 HMAC Richards**