ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Sheffield Health and Social Care Trust**
1	**CORONER** I am Alexandra Pountney, assistant coroner, for the coroner area of South Yorkshire (West District)
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 20 September 2022 an investigation was commences into the death of Gareth Etchells-Height born on 13 July 1979. The investigation concluded at the end of the inquest on 10 October 2023. The conclusion of the inquest was a narrative one and read:- *Following a deterioration in his mental health, Gareth Micheal Etchells-Heights died at the Wainwright Centre, 48 Wainwright Crescent, Sheffield, where he was found [redacted] by support staff with a ligature [redacted] Gareth intended to take his own life. There were various missed opportunities during Gareth's care, and his death was contributed to by a missed opportunity to communicate to him that he would not be discharged from the Wainwright Centre on 25 April 2022.* The cause of death was: (1)(a) Asphyxiation by ligature
4	**CIRCUMSTANCES OF THE DEATH** In January 2022, Gareth's mental health began to deteriorate culminating in an incident on 17 February 2022 when he was attended up by the British Transport Police at Sheffield Train Station and placed on a s.136, meaning that he was removed from the train station to a place of safety at the Longley Centre in Sheffield. Gareth was then subject to an assessment under the Mental Health Act between 23:05 hours on 17/02/2022 and 03:15 hours on 18/02/2022. During this assessment, Gareth was presenting with symptoms of psychosis, including delusional and persecutory thoughts.

	The assessment that was made of Gareth was that it was unclear whether the psychosis was long standing, or drug induced, and that Gareth was at risk of death by misadventure or retaliatory action. In circumstances where there was a query about whether the psychosis was drug induced, that "*usual practice would be to monitor for 2 -3 days if drug induced psychosis*"; this was not done on 18/02/2022. Gareth stayed for the remainder of the morning in the s.136 suite at the Longley Centre before leaving at approximately 11:30 hours. At approximately 14:30 Gareth phone HTT worried about his own safety. By 16:16 hours on 18/02/2022, the police had re-referred Gareth for assessment at the Longley Centre using their s.136 powers. He was then re-assessed between 14:00 and 19:45 hrs on 19/02/2022. The view that was taken by the assessing team was that Gareth's paranoid beliefs had progressed to identifying individuals colluding against him and that his "*presentation was markedly different"* to the previous assessment. It was assessed that the risk of "*significant self-harm was very high and … that the only option was to admit to hospital under s.2 of the MHA*." Gareth was then admitted to Maple Ward on 19 February 2022 and remained an inpatient until 22nd March 2022, when he was moved to a step-down bed at Wainwright Crescent. It should be noted that Gareth's section expired on 18th March 2022, and so he remained for the final few days as a voluntary inpatient. Sadly, Gareth's condition continued to deteriorate until in the early hours of the morning on 24 April 2022, he tied a ligature [redacted] at Wainwright Crescent Before Gareth died, he wrote a collection of notes were referred to as suicide notes.
5	**<u>CORONER'S CONCERNS</u>** 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. The **MATTERS OF CONCERN** are as follows. – **1. Discharge and safety netting** The discharge report for Gareth did not contain details of his diagnosis or sufficient information about high-risk behaviours/triggers. The information within the discharge report was not fit for purpose and did not provide for an accurate or full handover to new healthcare professionals. **2. Review of the medical notes** There was wholesale inconsistency in healthcare professionals reviewing medical notes before appointments, assessments, or handovers for Gareth. There was no written guidance on this issue and it lead to Gareth being seen by healthcare professionals who did not have an up-to-date understanding of Gareth's condition and mental state.

	3. Failure to update risk assessment There was a failure to update Gareth's risk assessment, which at the date of his death was last updated on 7 April 2022. Gareth's presentation had materially changed since 7 April 2022, and so the risk assessment effectively became redundant by virtue of the failure to update it. This impacted upon the ability of those caring for Gareth to identify and recognise changes in his behaviour that were triggers for acute mental health crisis or suicidal behaviours. In evidence it became apparent that the Trust did not have a system in place for routinely checking and updating the risk assessments. 4. **Record Keeping** There was a failure generally to keep proper records. It became clear as the evidence progressed that many of the record entries did not accurately or fully reflect the interactions with Gareth. There is no audit system in place to check the records.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 15 January 2024. 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 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 other person who I believe may find it useful or of interest. In this case I have sent a copy of this report to the CQC, the Local Authority and South Yorkshire Integrated Care Board. 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.
9	 **HMAC Alexandra Pountney** **20 November 2023**