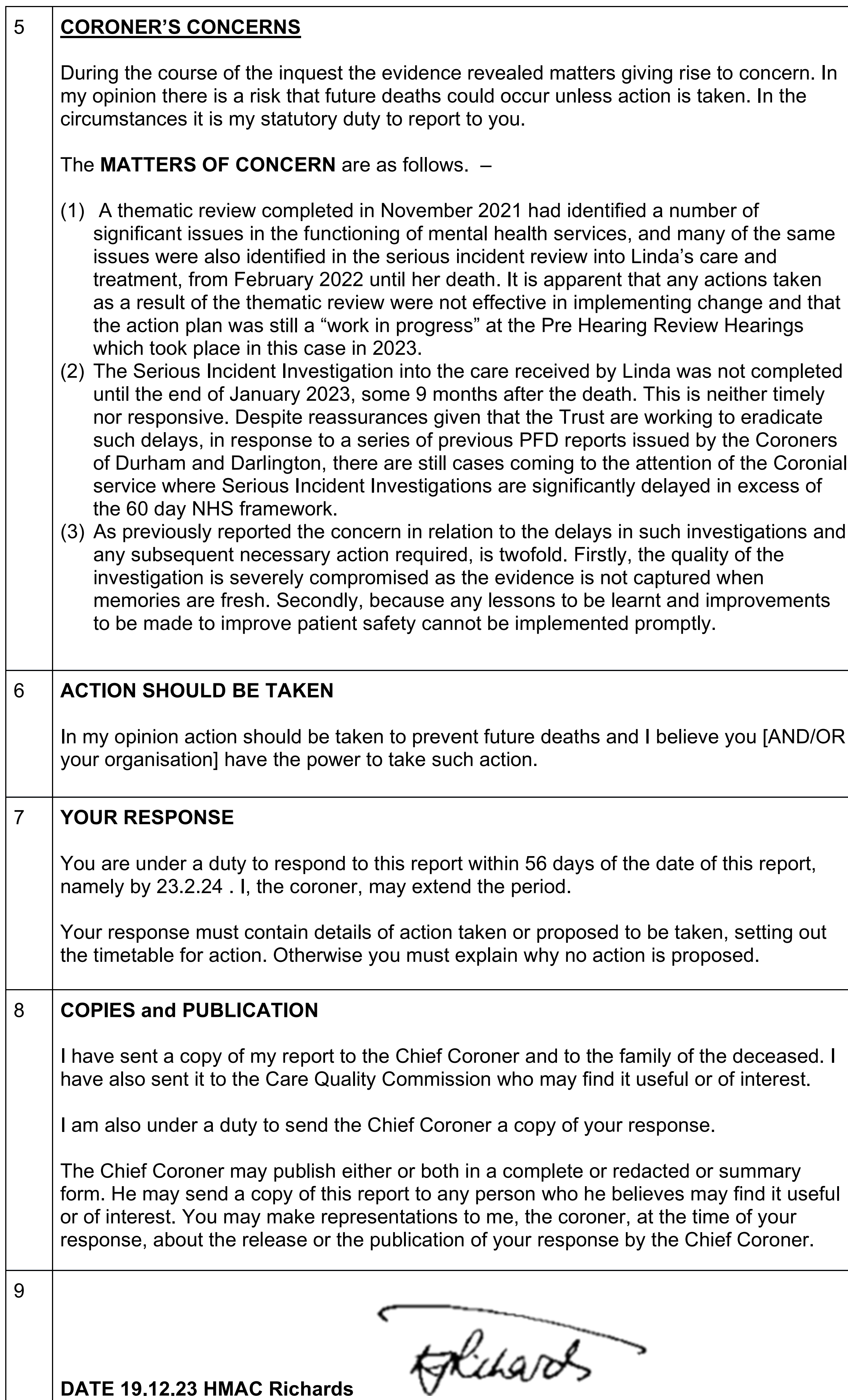
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [REDACTED], Chief Executive of Tees Esk and Wear Valley Acute NHS Trust**
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.

3	**INVESTIGATION and INQUEST** On the 19th of April 2022 an investigation was commenced into the death of Linda Louise Banks, aged 48 years. The investigation concluded at the end of the inquest on the 18th of December 2023. The medical cause of death was 1a) Paracetamol overdose with alcohol misuse. I gave a narrative conclusion as follows:- Linda Louise Banks died on the 10th of April 2022 at the University Hospital of North Durham. Linda had a history of alcohol misuse and mental health difficulties, including self harm and suicidal ideation. Linda also had learning difficulties which may have increased her vulnerability, which were not identified by vast majority of the mental health professionals, and there is no evidence that consideration was given to any reasonable adjustments that might be necessary, or as to any impact such may have had on her presentation, communication and understanding. Linda herself, her family and her friends, made multiple contacts with mental health services between February 2022 and her death, as her mental health deteriorated and concerns were expressed as to her safety. Referrals were also made by two external agencies, namely her GP and a home support agency, both expressing concerns about Linda's presentation. On each occasion risks were considered to be minimal and no further treatment or care was provided by mental health services. There were a multiplicity of difficulties revealed by a serious incident review which was extensively delayed and not received until the end of January 2023, some 9 months after Linda's death. It concludes that Linda did not receive the right care at the right time and her needs were not fully met, and included concerns, in summary, in relation to the quality of assessments and triage, quality of safety planning, poor record keeping, and further considers that there was an underestimation of risk and a lack of a trauma informed approach. I also find that these difficulties culminated in advice being given to a friend attempting to support Linda and communicated to her family, from an unknown mental health worker, that they should consider "tough love" and to effectively step back from their intensive support of Linda, thus removing an essential safety net in the absence of any ongoing mental health treatment or support. The identified failings cumulatively contributed to the death more than minimally. An earlier thematic review which had been completed in November 2021 identified many similar serious issues in the provision of mental health services, to those identified in this case, and it is clear that many of these issues were continuing at the time of Linda's death in April of 2022 and had not been addressed effectively by the Trust. On the 9th April 2022 Police forced entry to Linda's home, as a result of concerns raised by her family and friends and was taken to hospital by ambulance. She was hyperthermic and had low blood sugar and had taken an overdose of medication. Despite attempts to treat her she died in hospital on the 10th April 2022 as a result of the acute complications of paracetamol overdose on a background of alcohol related liver disease
4	**CIRCUMSTANCES OF THE DEATH** Linda Louise Banks died on the 10th of April 2022 at the University Hospital of North Durham as a result of an overdose of paracetamol against a background of alcohol misuse and subsequent to a deterioration in her mental health.



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) A thematic review completed in November 2021 had identified a number of significant issues in the functioning of mental health services, and many of the same issues were also identified in the serious incident review into Linda's care and treatment, from February 2022 until her death. It is apparent that any actions taken as a result of the thematic review were not effective in implementing change and that the action plan was still a "work in progress" at the Pre Hearing Review Hearings which took place in this case in 2023. (2) The Serious Incident Investigation into the care received by Linda was not completed until the end of January 2023, some 9 months after the death. This is neither timely nor responsive. Despite reassurances given that the Trust are working to eradicate such delays, in response to a series of previous PFD reports issued by the Coroners of Durham and Darlington, there are still cases coming to the attention of the Coronial service where Serious Incident Investigations are significantly delayed in excess of the 60 day NHS framework. (3) As previously reported the concern in relation to the delays in such investigations and any subsequent necessary action required, is twofold. Firstly, the quality of the investigation is severely compromised as the evidence is not captured when memories are fresh. Secondly, because any lessons to be learnt and improvements to be made to improve patient safety cannot be implemented promptly.
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 23.2.24 . 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 family of the deceased. I have also sent it to the Care Quality Commission 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	**DATE 19.12.23 HMAC Richards**