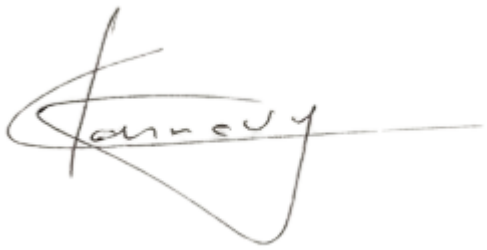
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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 Simon CONNOLLY, 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 24/03/2023 18:22an investigation was commenced into the death of Matthew Clive GALE 11/10/1985 00:00:00. The investigation concluded at the end of the inquest on 23/05/2024 14:17. The conclusion of the inquest was that Matthew's death occurred on 19th March 2023 at [redacted]. Matthew had a history of mental ill-health dating back to June 2017 including periods as a patient in West Park Hospital. Matthew had a schizoaffective episode in February 2023 and was admitted to Maple Ward of West Park Hospital. Treatment plans were put in place but Matthew's condition deteriorated from 6th March 2023 and he was formally detained under the Mental Health Act on that day. He was granted Section 17 leave on the 8th March but there are no records to support this. The conditions of his leave were widened and incorrect forms were used and the conditions were not conveyed to Matthew's family. The salient condition was that Matthew should not be left alone and the failure to communicate contributed..
4	**CIRCUMSTANCES OF THE DEATH** Matthew's death occurred on 19th March 2023 at [redacted]. Matthew had a history of mental ill-health dating back to June 2017 including periods as a patient in West Park Hospital. Matthew had a schizoaffective episode in February 2023 and was admitted to Maple Ward of West Park Hospital. Treatment plans were put in place but Matthew's condition deteriorated from 6th March 2023 and he was formally detained under the Mental Health Act on that day. He was granted Section 17 leave on the 8th March but there are no records to support this. The conditions of his leave were widened and incorrect forms were used and the conditions were not conveyed to Matthew's family. The salient condition was that Matthew should not be left alone and the failure to communicate contributed.
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) At inquest, Matthew's mother gave evidence that she was never informed of the terms upon which Matthew's section 17 leave had been authorised by those responsible for his treatment and specifically that Matthew should never be left alone or unaccompanied whilst on section 17 leave nor was she provided with a copy of Matthew's section 17 leave form. The Trust acknowledged and admitted that there was no evidence in any records available to it that such discussions had been had with Matthew's mother or that a copy of the section 17 leave form had been provided to her. The Trust gave evidence of changes implemented since Matthew's tragic death to avoid future recurrence and I requested additional evidence from the Trust in relation to audited compliance data. Notwithstanding changes already implemented and envisaged and by its own admission, the Trust's compliance data is "inconsistent" generally but specifically in relation to the provision of the section 17 leave form to a carer/ person accompanying a patient subject to section 17 leave. That evidence demonstrated a 50% compliance rate in December 2023, a 52% compliance rate in March 2024 and a 76% compliance rate in May 2024, with a compliance rate of 80% or above considered to be "good" by reference to the Trust's compliance criteria. Additionally and in relation to changes already implemented, the Trust's evidence at inquest was that its revised section 17 leave policy for detained patients had removed the previous requirement that the section 17 leave form ought tot be signed by the person accompanying the patient, the explanation for this being the Trust's roll-out of a new digitised system. The inconsistent compliance audit data referenced above gives rise to a concern that there is risk that future deaths could occur consequent to this change unless action is taken.
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 September 13, 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 following Interested Persons [redacted] **Watson & Woodhouse Solicitors** I have also sent it to 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: 13/08/2024**  **Simon CONNOLLY** **Assistant Coroner for** **County Durham and Darlington**