Regulation 28 Report to Prevent Future Deaths

Coroners and Justice Act 2009
Coroners (Investigations) Regulations 2013

THIS REPORT IS BEING SENT TO:

- The Chief Executive Officer of the Coventry and Warwickshire Partnership Trust

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1. **CORONER**:
   I am Linda Lee, Assistant Coroner for the coroner area of Coventry and Warwickshire

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2. **CORONER'S LEGAL POWERS**:
   I make this report under paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulation 28 of the Coroners' (Investigations) Regulations 2013.

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3. **INVESTIGATION AND INQUEST**:
   On 14 July 2023, an investigation was commenced into the death of Darren Joseph Hope, who died on the 3 July 2023 aged 53.

   The investigation concluded at the end of the inquest before me and a jury on 24 October 2024.

   The conclusion of the Jury was:

   Medical cause of death:

   1a Multiple Injuries

   Darren Joseph Hope died as a result of suicide. Some factors that contributed to this were him being allowed to leave after being assessed as low risk despite threats to himself and others, and him being unaccompanied despite having been assessed already that he should be accompanied.

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4. **CIRCUMSTANCES OF THE DEATH**:

   Darren Joseph Hope had a background of increasing mental health problems and prior involvement with the police. On 29 May 2023, he was

taken to the Caludon Centre (the Centre) by the police and admitted under Section 2 of the Mental Health Act. Due to an administrative error, he was initially treated as a voluntary patient for several days before being formally detained under Section 3 of the Mental Health Act. He had a diagnosis of schizoaffective disorder.

Darren was deemed suitable for unescorted Section 17 leave, against a history of absconding, using alcohol and cannabis while on unescorted leave, and expressing suicidal thoughts while on unescorted leave at home. It does not appear that the Responsible Clinician was given this information.

Darren was granted six hours of unescorted leave. However, the Section 17 leave form signed by the Responsible Clinician indicated that he was to be accompanied by family members. The Responsible Clinician later reported this was an error, as he had intended to grant unescorted leave. The Responsible Clinician also stated that even if all of the events had been drawn to his attention, he would still have granted unescorted leave.

On the morning of 3 July 2023, Darren appeared happy and optimistic about the future when he utilised his six-hour unescorted leave at approximately 11:15 am. He returned to his home address at around 2:15 pm. Darren lived in a 10th-floor flat. At approximately 3:20 pm, he was found at the base of the building and was pronounced dead. The cause of death was determined to be multiple injuries due to a fall from height.

At the time of his leave, Darren did not have a mobile phone, as it had been retained by the police on his arrest, prior to admission to the Centre. He did not have a landline, and it appears he did not have means of accessing his bank accounts, and no cash was found on his person. The evidence suggests that Darren had no means of contacting the Centre or anyone else if he had concerns, nor could the Centre contact him during his leave. His inability to contact or be contacted was not considered when granting his leave or when signing him out of the ward on 3 July 2023.

A subsequent investigation and Patient Safety Incident Investigation Report (the Report), dated 18 January 2024, did not "*identify a requirement for the implementation of any safety actions*."

The Report noted that on 3 July 2023 Darren had been granted over the six hours permitted, as he left at 10:15 am [sic] and was not required to return until 6 pm.

The Report also noted that on 3 June 2023, Section 17 leave would have been permitted even though there was no Section 17 leave form in place on that date. Leave did not take place due to misplaced keys.

The Report did not note that the Section 17 leave form in place on 3 July 2023 only permitted unescorted leave.

The Report did not note that Darren's method of communicating with the Centre had not been considered at any point.

The inquest received evidence that the investigating officer was not required to inform the oversight team who sign off the Report—the Significant Incident Group (the SIG)—of any issues that had arisen during the investigation and subsequently disregarded. The evidence did not explain how the SIG was able to provide meaningful oversight on the basis of reviewing the draft report only.

Although the inquest received evidence regarding proposed changes around Section 17 leave, this was not reflected in the evidence of staff members directly involved in patient care.

The Report states that, "*The investigation team follow the Duty of Candour and the Engaging and Involving Patients, Families and Staff after a Patient Safety Guidance in their collaboration with those affected, to help them identify what happened and how this resulted in a patient safety incident*."

The inquest received evidence that Darren's mother had been contacted once by telephone call and once by text message, but she and the wider family were not given the opportunity to participate or raise issues. They were not provided with any information about Darren's care or any other information which would have enabled them to participate in any significant way.

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5. **CORONER'S CONCERNS**:
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 these concerns to you.

The **MATTERS OF CONCERN** are as follows:

- **Concern 1**: Section 17 leave conditions may not always be thoroughly reviewed or clarified before a service user is signed out for leave. This lack of verification can lead to unaddressed discrepancies, which may impact the safety and appropriateness of unescorted leave.
- **Concern 2**: There may be a lack of accessible or reliable means for service users on unescorted leave to contact the facility if they encounter difficulties. This could impact their ability to seek support or assistance when needed.
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- **Concern 3**: There may be limitations in the reporting system's ability to identify and address substantive issues that directly impact patient safety. If critical concerns are overlooked, there is a risk that valuable

insights for preventing future incidents may be missed, reducing the system's effectiveness in promoting long-term safety improvements.

6. **ACTION SHOULD BE TAKEN**:
   In my opinion, action should be taken to prevent future deaths, and I believe you, have the power to take such action.

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7. **YOUR RESPONSE**:
   You are under a duty to respond to this report within 56 days of the date of this report, namely by 30 December 2024. I, the coroner, may extend the period if necessary.
   Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Alternatively, you must explain why no action is proposed.

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8. **COPIES AND PUBLICATION**:
   I have sent a copy of my report to the following interested persons:
   - Darren's family
   - West Midlands Police
   - I am also under a duty to send a copy of this report to the Chief Coroner and to publish it on the Judiciary website but may redact the report before publication if appropriate.

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9. **DATED**: 4 November 2024
   Linda Lee
   Area Coroner for Coventry and Warwickshire