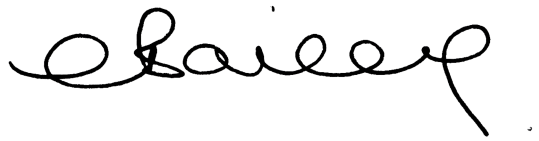
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Department of Health and Social Care** **2 Chief Executive of Integrated Care Board (NHS North East and North Cumbria)** **3 Chief Executive of Tees Esk and Wear Valley NHS Mental Health Foundation Trust** **4 Chief Executive of Middlesbrough Council** **5 Chief Executive of Stockton Council** **6 Chief Executive of Hartlepool Council** **7 Chief Executive of Redcar Council**
1	**CORONER** I am Clare BAILEY, Senior Coroner for the coroner area of Teesside and Hartlepool Coroner's Service
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** Mr Dean Bradley died on 15th October 2021 at [redacted], Stockton on Tees. An inquest into Mr Bradley's death was opened on 28th July 2023 and his inquest was heard before me on 19th May 2025. The medical cause of Mr Bradley's death was: 1a. Pressure on the neck 1b. Hanging It was discovered in toxicology testing that the level of Venlafaxine in his blood was around twenty times that expected from a therapeutic dose and in the range associated with fatality. A narrative conclusion was given: "Dean Bradley hanged himself on the morning of 15th October 2021 in [redacted], Stockton on Tees whilst under the influence of excess amount of prescribed medication. The police failed to contact the mental health services when they assisted him at Thornaby station earlier in the day and failed to adequately relay details of his mental health crisis to staff at the hostel. The staff at the hostel failed to respond to information provided by the police. There were missed opportunities by both Cleveland Police and the hostel to involve mental health professionals and secure appropriate mental health support for Dean."
4	**CIRCUMSTANCES OF THE DEATH** At approximately 0300 on 15th October 2021 Mr Bradley was found by the police walking on a dual carriageway. Following a discussion in which he revealed he was homeless the police secured emergency overnight housing for him at a hostel. There were no concerns for Mr Bradley's mental health at that point.

	Mr Bradley was seen outside the hostel at 0450 and was met by the security officer. He spoke of people being after him. He was reassured and taken back to his flat. Mr Bradley left the hostel unwitnessed by the security officer. At 0540 a member of the public came across Mr Bradley sat on a bridge over a railway line. Mr Bradley stated he intended to kill himself. The member of the public spoke with Mr Bradley and called the police. During his time with the member of the public Mr Bradley moved himself as if to jump in front of a train when he thought a train was coming. The police attended. The police succeeded in bringing Mr Bradley down from the bridge and spoke with him in the police van. The officers came to the conclusion that Mr Bradley was under the influence of drugs. One of the officers raised concerns about Mr Bradley's mental health as he was expressing persecutory beliefs and appeared paranoid and delusional. He believed that people were chasing him and wanted to kill him. The police considered contacting the Crisis Team and other mental health services but did not do so. The main reason for this is that, in their shared experience, the mental health services would tell them to safeguard Mr Bradley until he was sufficiently sober to be assessed. The police returned Mr Bradley to the hostel and, with the assistance of the security officer, Mr Bradley was shown CCTV of the premises. The purpose of showing Mr Bradley the CCTV was to prove no one was chasing him. Mr Bradley reportedly relaxed and accepted that no one was pursuing him. The police determined that the risk of suicide and self-harm had lessened and that it was safe and appropriate to leave Mr Bradley at the hostel. The police did not adequately relay the circumstances in which they found Mr Bradley to the security officer at the hostel. There was a brief comment that he was found sitting on the edge of a bridge at the station. The security officer did not enquire further. The security officer saw Mr Bradley leave his flat at approx. 0720. Mr Bradley refers to people being after him again. The security officer met with Mr Bradley, reassured him and took him back to his flat. Staff from the hostel knocked on Mr Bradley's door at approx. 1015 as he had not left the flat. There was no response. Police attended and Mr Bradley as found deceased, hanging in his flat. The staff from the hostel were clear that the hostel was not a place for a person suffering from a mental health crisis. Residents are not checked upon, it is a service which provides accommodation only. Evidence was received from a Detective Chief Inspector who concurred. He also gave evidence as to Right Care Right Person initiative. He spoke of Crisis Cafes and Calming Centres in other regions where people who are under the influence of drugs or alcohol and present with metal health concerns may be supervised pending a mental health assessment. There appears to be a gap in the services available for people in this category. The officer spoke of a discussion with Middlesbrough County Council about provision of such a service. I stress that I did not make a causal link between Mr Bradley's death and the unavailability of this resource. Neither the local authorities in this jurisdiction, the Integrated Care Board (NHS North East & North Cumbria), Tees Esk and Wear Valley NHS Mental Health Foundation Trust nor the Department of Health were Interested Persons in the inquest. They did not give evidence at the inquest as the concerns raised did not come to light until the hearing.
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) 1) Current resources for safeguarding those with mental health illnesses whilst intoxicated may be placing people at risk. 2) I heard evidence that a person who was suicidal, suffering with mental health concerns and was intoxicated could not be adequately safeguarded until he was sufficiently sober to allow a mental health assessment.
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 July 23, 2025. 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 **Watson Woodhouse – Legal representative for Mr Bradley's family** I have also sent it to **Cleveland Police** **New Walk CIC** 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: 28/05/2025**  **Clare BAILEY** **Senior Coroner for** **Teesside and Hartlepool Coroner's Service**