CAIN ALEX RIVER DONALD

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:** Chief Executive, Oxford Health NHS Foundation Trust
1	**CORONER** I am Nicholas Graham, Area coroner, for the coroner area of Oxfordshire.
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 11/08/2022 I commenced an investigation into the death of Cain Alex River Donald, aged 26. The investigation concluded at the end of the inquest on 7 May 2025. The conclusion of the inquest was Suicide. The medical Cause of Death was Hanging
4	**CIRCUMSTANCES OF THE DEATH** Cain Donald died on 29 July 2022 by hanging. Prior to his death, Mr Donald had been released from prison in December 2019 and remained on Probation. He experienced a decline in his mental health in June 2022, exhibiting paranoid behaviour and using substances. He was admitted to Ashurst Psychiatric Intensive Care Unit (PICU) on 28 June 2022 and was discharged directly into the community on 19 July 2022 following a decision by a Mental Health Review Tribunal. Following discharge, he was receiving support from the Crisis Home Treatment Team (CRHTT). The inquest specifically focused on the events preceding his death, particularly his discharge planning, the involvement of the Probation Services and his family, and the role of the CRHTT, including medication administration. I found deficiencies in the planning and execution of his discharge.
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 to you. The **MATTERS OF CONCERN** are as follows. – **Planning of discharge from detention under the Mental Health Act at Ashurst PICU directly into the community.**

	(1) The evidence revealed deficiencies in the way Mr Donald's discharge was planned and executed, specifically that his family and the Probation Services were not properly engaged in the discharge planning process when they were considered important mitigations in any risk Mr Donald posed to himself. (2) There was insufficient communication and liaison with family members, including explaining Mr Donald's condition and risks on discharge and providing support to his partner as a carer. The Probation Service was not informed of the discharge meeting and should have been invited and participated; and Mr Donald's family were unable to contribute effectively to the discharge process. My principal concern was that the Trust's Discharge Policy did not seem to specifically envisage discharge to the community by a Tribunal directly from the PICU. Such a decision necessitates rapid coordination of complex discharge arrangements and effective engagement of relevant agencies and the family, which was absent in Mr Donald's discharge. Whilst the Trust has taken some action to acknowledge these issues, I remain concerned that the specific issues outlined above have not been adequately addressed. **Post-discharge management of risk arising from medication compliance and multi-disciplinary team review.** (3) Evidence suggested that during the period immediately prior to Mr Donald's death, staff of the CRHTT did not implement specific instructions to supervise Mr Donald taking his medication. By 24 July 2022, a decision had been made that Mr Donald should be supervised when taking his medication, but this direction was not adhered to in the following days. Escalation of this issue did not occur. There was no evidence of steps taken by the Trust since Mr Donald's death by way of training or guidance to CRHTT staff to address these issues. My conclusion was that had supervision and escalation taken place, it is possible this may have prevented a deterioration in Mr Donald's mental health which led to his death.
6	**DETAILS OF ACTION TAKEN BY RECIPIENT** As well as the actions the Trust has already undertaken, the Trust should review the discharge planning arrangements to ensure their effectiveness, particularly in the light of any Tribunal decision requiring discharge from detention, and specifically in relation to discharge from the PICU. Furthermore, the Trust should review arrangements for the medication supervision by staff from the CRHTT and also how concerns about medication compliance are escalated and risks reviewed in the light of suspected or actual non-compliance.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 31 July 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:

	[redacted] and [redacted] (acting on behalf of themselves and Cain's four siblings). Thames Valley Probation Services 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. The Chief Coroner may publish either or both in a complete or redacted or summary form. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.
9	**[DATE] 05/06/2025** **[SIGNED BY CORONER]** Nicholas Graham