South West London and
St George's Mental Health
NHS Trust

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Private & Confidential

Paul Rogers
HM Assistant Coroner Inner West London
Inner West London Coroner's Court
33 Tachbrook Street
London
SW1P 2ED

Our internal Reference: Incident Number 107836 (2022)

Dear Mr Rogers,

Re: Regulation 28 Report to Prevent Future Deaths – Mr Gareth Jackson

I am writing in response to the Regulation 28: Report to Prevent Future Deaths, dated 8 August 2025, concerning the tragic death of Mr Gareth Jackson.

South West London and St George's Mental Health NHS Trust (SWLStG) acknowledges the matters of concern raised in your report and takes them very seriously. We have reviewed these issues with our clinical leadership team and are committed to ensure that lessons are fully embedded across our services.

Our response will be shared with the Trust Board Quality Committee in October 2025 and the Public Board in November 2025.

Below we set out the concerns from your PFDR, followed by the Trust's actions.

The MATTERS OF CONCERN

I heard evidence that there had been changes to the policies and templates aimed at addressing risk around leave and safety off ward. This was still ongoing. It was accepted in evidence that the acute ward operational policy and leave policy needed

to be reviewed again to makes sure the various polices including risk management policies were aligned. For example, on the Day 2 checklist for review there was no placeholder for leave/off ward safety management. I was told that there was a positive move to review thinking around risk more as safety rather than simply as risk management, but this was a new concept. I noted that in the templates now used to consider nursing reviews and handovers, there was no specific place to consider leave management and safety around this, expecting it instead to be addressed in the plan – albeit there was a reminder to consider this on the template.

To that extent it appeared little substantial had changed from the process before, and the policies remained unaligned. I am concerned that safety planning around leave/going off ward/unit as a voluntary patient has not been given the prominence it requires, as was required in the case of Gareth where the plan for his safety off ward had not been identified by staff on Ward 2 effectively.

As such my concern as to future death if this were to not to be unaddressed comprehensively, continues.

At the inquest, our Clinical Director for Acute and Urgent Care, Dr Razvan Gutu, described a number of immediate improvements that had already been made in response to this case. These included:

- Improving communication and information-sharing around risk, especially at ward transfers and with families.
- Strengthening observation procedures and standardising Multi-Disciplinary Team (MDT) handovers.
- Undertook audits around compliance around patient leave for informal patients.
- Increasing early senior medical review, supported by additional full-time middle-grade cover.
- Reinforcing the approach to risk assessment for informal leave.
- Re-briefing all wards on door security practices.
- Further embedding the Trust's 11 Fundamental Standards of Care with monthly audit/oversight, and
- Reinforced the requirement to undertake on-line observation training for all ward-based staff which is closely audited
- Established a new inpatient-rotation induction programme for junior doctors covering requirements for risk assessment and documentation, especially for informal patients granted leave.

We recognise, however, that the Prevention of Future Deaths Report highlighted ongoing concerns requiring further action in particular around ensuring our documented policies align and translate into documentation to support and prompt staff to follow them. Since receiving the PFDR, we have taken the following additional steps:

Revised Trust Leave Policy – Strengthened requirements for risk assessment, MDT collaboration, safety planning, and explicit guidance on holding powers for informal patients. This revision was approved by our Mental Health Law Group on 23 September 2025.

Enhanced Adult Inpatient Operational Policy – A new dedicated section on Leave has been added to provide clarity for our staff, covering:

- Key safety principles.
- The leave request procedure, assessment, and safety planning process (including during leave).
- Escalation and documentation requirements.
- Specific guidance on informal patients and family engagement.
- Updates to the Admission and Discharge Planning Checklist to ensure patients are informed that leave will always be subject to an agreed safety plan.

Alignment with other key policies – The revised Adult Inpatient Operational Policy now makes explicit links to the:

- Trust Patient Leave Policy
- Clinical Risk Management Policy
- Absent Without Leave (AWOL) Policy

The changes to the Adult Inpatient Operational Policy and Leave Policy, together with a broader cross-policy review, have helped ensure there is no misalignment.

Learning briefing / Frequently Asked Questions – A learning brief about the patient's care was shared, and a set of Frequently Asked Questions (FAQs) was developed to provide staff with practical guidance on managing leave and working collaboratively with patients, families, and carers, with particular attention to informal patients.

Updated Handover and Review Templates – The MDT and Nursing Handover templates, as well as the Care Plan Review Meeting (CPRM) template, have been updated to include a dedicated section for reviewing safety plans linked to leave. A new heading, "Safety Plan for Using Leave," has been added to all of the above templates.

Door security – The arrangements were further reviewed against best practice standards and were found to be aligned. However, the review emphasised that staff must remain fully aware of their responsibilities when accessing doors, ensuring that unauthorised individuals are not allowed entry or able to tailgate. Additional briefings on security practices have since been provided.

Training – The Collaborative Clinical Safety Training (CCST) has been updated to incorporate learning and reflections from this case, with emphasis on leave safety planning, risk assessment and the legal framework around informal patients.

Assurance - We have introduced checks to confirm that staff are aware of the changes and the associated expectations. Compliance with these requirements will be subject to ongoing audit and monitoring to ensure that improvements are fully embedded in practice and will initially be subject to quarterly audits. In addition, our Mortality Committee oversees the actions arising from PFDRs to provide assurance that they are progressing appropriately and completed in full and are checked on an annual basis thereafter.

As acknowledged during our own investigation and at the hearing, the Trust recognises that Gareth's death was preventable, and we take full responsibility for the failings in his care. On behalf of the Trust, I extend my deepest and sincerest condolences to Mr Jackson's family.

We are committed to ensuring that the actions outlined above are fully implemented, monitored, and sustained so that such a tragedy does not recur. We are also grateful to all those involved in the inquest process, whose contributions continue to strengthen our efforts to improve patient safety and care.

Yours faithfully

Vanessa Ford
Chief Executive
South West London and St George's Mental Health NHS Trust