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 NHS England Improvement (PFDs)** **2 Deputy Director of Patient Safety NHS England** **3 National Director FOR Mental Health** **4 Health Services Safety Investigations Body (HSSIB)**
1	**CORONER** I am Anita BHARDWAJ, Area Coroner for the coroner area of Liverpool and Wirral
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 17 March 2025 I commenced an investigation into the death of Charles Andrew STONLEY aged 50. The investigation concluded at the end of the inquest on 19 August 2025. The conclusion of the inquest was that: Narrative Conclusion: Self ligatured whilst suffering from a psychotic episode
4	**CIRCUMSTANCES OF THE DEATH** Charles Andrew Stonley was a 50 year old gentleman who had a medical history of severe depression with psychotic features (diagnosed in 2018) for which he was on medication. In September 2023 Charles had been detained under section 2 of the Mental Health Act. On 12 March 2025 Charles attended Arrowe Park Hospital at 8.51pm with suicidal ideations, he was tearful, psychotic and paranoid. There were no mental health rooms available in the Emergency Department due to them being occupied by other patients and so Charles was put in a cubicle near to the nursing bay (cubicle 7). This was more exposed to the busy Emergency Department and so potentially more detrimental than if he had been in a quiet room specifically for patients suffering a mental health crisis. The plan being if Charles wanted to leave the Department, a capacity assessment would be carried out and if he then left Department the missing person alert process would be instigated with the police. Charles was assessed and agreed to an informal admission to a mental health unit. Charles was awaiting a bed to be made available and remained in the Emergency Department in the cubicle. On the morning of 13 March 2025 at 2am he was suffering with increased agitation and displaying psychotic symptoms; at 2.25am a capacity assessment was carried out where he was deemed to lack capacity; at 3.30am and at 4.22am he left the hospital but was returned on both occasions and he attempted to leave on several occasions thereafter; at 7am he was calm and administered medication. A short time after 8am Charles again left the department stating he was going to take his own life. Merseyside Police were contacted by staff at Arrowe Park Hospital to report Charles had been pursued by security officers into the woods. A short time later Charles was found deceased hanging in a wooded area, near to Arrowe Brook Lodge, near to a public car park off Arrowe Brook Road. He was hanging by an electrical cable hooked over a broken

	branch. The toxicological analysis revealed nothing of significance and the post mortem found Charles died by hanging. Throughout this period there were no legal powers to forcefully detain Charles within the emergency department. It is more likely than not that if a mental health bed had been available within a reasonable time, namely a few hours, the outcome for Charles would have been different and prevented him from leaving the Emergency Department and carrying out the act of self harm he subsequently did.
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: 1. The legal powers and resources available for mental health patients in the Emergency Department of Hospitals is limited and as such detrimental to those attending Accident and Emergency Departments when suffering from a mental health crisis. 2. The severe shortage and availablity of beds in mental health facilities resulting in vulnerable patients being left in the Emergency Department for days increasing the risk of self harm and death.
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 October 15, 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 1. The Family of Charles Andrew Stonley 2. Wirral University Teaching Hospital NHS Trust (WUTH) 3. Cheshire and Wirral Partnership NHS Trust (CWP) 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. They may send a copy of this report to any person who they believe 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: 20/08/2025**

Anita BHARDWAJ
Area Coroner for
Liverpool and Wirral