REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Chief Executive, South West London and St Georges Mental Health NHS Trust [redacted], South West London and St Georges Mental Health Trust
1	**CORONER** I am Paul Rogers, HM Assistant Coroner, for the Coroner Area of Inner West London
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 the 4th – 8th August 2025 evidence was heard touching the death of Gareth Ian JACKSON. He died on 22nd June 2022 aged 44 years. **Medical Cause of Death** I (a) Multiple Traumatic Injuries **How, when, where Gareth Ian JACKSON came by his death:** In February 2022 following infection from CoVid Gareth Jackson began to develop symptoms of anxiety and depression which led to him seeking medical help from his GP. He was prescribed sertraline in March 2022 but he stopped taking this. He did engage with some talking therapies. He began to deteriorate further during April into May 2022. He was ruminating on failures he perceived at work, and around financial worries. In June 2022 he tied a ligature [redacted]. On 13th June 2022 Gareth Jackson travelled to [redacted] with the intention to end his life. He did not do so and after speaking to police and a local mental health nurse, he returned to his home in London. Throughout February to June 2022 his wife Donna and his family did all they could to seek help and treatment for him. Later on the night of 13th June into 14th June he was assessed by local mental health nurses and

	agreed to attend the Coral Unit at Springfield Hospital, Glenburnie Road, SW17 7DJ where he was assessed. It was concluded he was at high risk of suicide. Gareth agreed to remain at the Coral Unit and the plan was to transfer him to the Lotus Unit at the hospital for further assessment. He was transferred to Lotus where he remained until 21st June 2022 which it is admitted was longer than he should have done while waiting for an inpatient bed due to a national bed crisis. He remained at high risk of suicide throughout. He remained a voluntary patient and a plan was made by a consultant psychiatrist from Lotus to admit him to Ward 2 at Springfield, an acute mixed adult psychiatric ward. If he wished to leave the hospital temporarily the plan was he should be escorted by a staff member or his wife. He agreed to this plan. This requirement was included in his treatment plan and was to remain the plan until it was altered by a consultant. On his transfer to Ward 2 there was an inadequate handover and a failure to ensure this part of the plan was communicated properly to nursing staff. On ward 2 he was assessed by doctors as part of the clerking arrangements and again this part of the plan was inadequately recorded in the clerking notes and not properly handed over to nursing and medical staff. This led to a failure by nursing and medical staff on ward 2 on 22nd June 2022 to properly understand the plan, or to properly review the consultant note of 20th June 2022, and as a result to properly understand the risks Gareth posed to himself and the measures that needed to be in place to protect his life. As a consequence when Gareth requested unescorted leave on 22nd June 2022 he was permitted to leave the hospital unescorted because medical and nursing staff had failed to identify the plan for him not to leave unescorted. It is accepted by the Trust that: (i) there was a lack of clear procedure in place for handover on internal transfers at the time of Gareth's death; (ii) there was a lack of clear procedure in place for handover between outgoing/incoming teams on Ward 2; (iii) there were shortcomings in the record keeping relating to Gareth's transfer to Ward 2 from Lotus and the communications that followed; (iv) the plan implemented by the Consultant Psychiatrist on Lotus was not followed pending further senior review on Ward 2; (v) there was a failure to assess Gareth adequately on 22nd June 2022 following requests for unescorted leave; (vi) the requests for leave on 22nd June 2022 should not have been approved, pending a review by a senior doctor or consultant; (vii) Gareth should not have been granted unescorted leave from the Ward on the occasions this was granted on 22nd June 2022 and that had Gareth not been granted unescorted leave on that day his tragic suicide would likely have been prevented. If the plan from Lotus had been properly identified by nursing and medical staff at handover from Lotus and at any time on Ward 2 prior to him leaving for the second time he would not have been permitted unescorted leave and would not have left the hospital. Instead, Gareth did leave the hospital via a swipe door into the car park where he was permitted to leave by a staff member without challenge. He left the hospital and ran towards the [redacted] where he [redacted] onto the running lines and rails intending to end his own life where he was struck by a train that had no time to stop. The combination of the fall and strike by the train caused multiple injuries from which he died below

[redacted] at 1534 on 22nd June 2022.

The following matters were causative of Gareth's death:

(a) The failure by nursing staff to provide an accurate oral and documented handover on 21st June 2022 and thereafter through 21st into 22nd June 2022 that effectively communicated Gareth's plan that he should not have unescorted leave
(b) The failure by nursing staff on ward 2 on 21st June 2022 to properly review Gareth's medical notes to identify the plan that he should not leave the ward unescorted including by entry on the whiteboard in the nursing station on ward 2
(c) The failure by medical staff to ensure the plan that Gareth should not have unescorted leave was clearly communicated to nursing and medical staff after clerking on 21st June 2022
(d) The serious failure by nursing and medical staff on 22nd June 2022 to identify the plan that Gareth should not have unescorted leave and as a result the serious failure to adequately risk assess the harm Gareth presented to himself before granting him leave
(e) The failure by nursing and medical staff to speak to Gareth's family before and after the decisions to grant him leave
(f) The decision to grant Gareth leave by both nursing and medical staff on 22nd June 2022
(g) The failure to prevent access by non-staff members to the staff only area of the stairwell leading to the secure door to the car park

The following matters are possibly causative of his death:

(a) The failure to agree and document when Gareth would return from leave on 22nd June 2022
(b) The failure by staff to challenge Gareth, a non-staff member in the staff stairs prior to opening the door for him and permitting him to leave on the second occasion on 22nd June 2022.

Conclusion of the Coroner as to the death:

"On 22nd June 2022 Gareth was permitted to leave Ward 2, an acute psychiatric ward at Springfield Hospital by nursing and medical staff when he should not have been. This occurred as a result of failures by nursing and medical staff on 21st and 22nd June to properly identify, document and communicate to other staff the plan from 20th June 2022 that any leave should have been escorted. Nursing Staff on 21 and 22nd June failed to appreciate this plan because it had not been properly handed over and documented on transfer between Lotus Unit and Ward 2, and thereafter was not properly documented or communicated to staff after clerking at each handover prior to death. Nursing staff on ward 2 failed at any time to identify and understand the plan from Lotus that leave should be escorted. Medical staff on ward 2 on 22nd June also failed to understand this plan and as a result of both nursing staff and medical staff failures to understand the plan and thus carry out a

	proper risk assessment on 22nd June, Gareth was permitted to leave. Both nursing and medical staff on 22nd June 2022 failed to communicate the decisions around leave to Gareth's family and seek their input. Gareth was able to enter the staff only stairwell through an unlocked door and left the hospital grounds through a swipe operated staff door. He exited through the car park and ran to [redacted] where shortly thereafter he took his own life on 22nd June 2022 by [redacted] onto the tracks below intending to end his life whilst suffering from the effects of a depressive illness and anxiety which affected his otherwise reasonable judgment."
4	**Circumstances of the death:** Extensive evidence was heard by the court in the form of written and oral evidence, including expert evidence. Of particular significance for the purpose of this report are the following matters: (1) There were repeated failures by nursing and medical staff to read, understand and replicate plans around safety off the ward or unit, which erroneously led to Gareth being permitted leave when he should not have been. (2) Part of the reason for this was a lack of joined up policy and risk management around how safety on leaving the unit or ward was being assessed in the case of voluntary patients creating ambiguity according to the RCA review.
5	**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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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: The Family of Gareth Ian Jackson South West London and St Georges Mental Health NHS Trust I am also under a duty to send the Chief Coroner a copy of your response. 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	**8th August 2025** **Paul Rogers** **HM Assistant Coroner Inner West London** **Inner West London Coroner's Court** **33 Tachbrook Street** **London SW1P 2ED**