Alternative Futures Group

HM Coroner for Cheshire
Cheshire Coroner's Court
Museum Street
Warrington
WA1 1JX

1st May 2026

Dear Madam

Inquest touching upon the death of Ruairi Stewart – Regulation 28 response

Thank you for providing a copy of your Regulation 28 report, dated 10 March 2026.

Alternative Futures Group Limited ("AFG") operates Weaver Lodge Independent Hospital. We have carefully considered the concerns identified, which have been reviewed at senior clinical and executive level, including oversight by AFG's Board-level Quality and Safety Committee. We set out below the organisation's response, including actions taken and further measures to be implemented to mitigate the risk of recurrence.

AFG recognises the seriousness of the issues identified and has taken steps to ensure that learning is embedded and subject to ongoing organisational oversight.

<u>MDTs</u>

Concern 1

The timing of the shifts of the named nurse for the patient meant that she was not able to attend any MDT for the patient over many months and her input was therefore only in writing.

Actions taken:

- An updated standard operating procedure has been implemented requiring MDT scheduling to take account of named nurse availability.
- Where attendance of an individual's named nurse is not possible, for example due to annual leave commitments, an appropriate alternative clinician is required to physically attend in their place. That individual will undertake preparation with the patient prior to attendance, to ensure all relevant information is captured and considered.
- Attendance at MDTs by a patient's named nurse, or an alternative in their place, is formally recorded, with ongoing compliance monitored through routine monthly audits by a senior practitioner.

Concern 2

The named nurse written reports provided inaccurate information to the MDT, giving a reassuring picture of compliance which is not reflected by the written records.

Actions taken:

- A standardised MDT reporting template has been introduced into the Digital Support Record (DSR) system, AFG's electronic patient record software. The named nurse (or an alternative individual, as detailed in response to Concern 1) is sent the template attached to the MDT invite, and is required to complete this form seven days prior to the MDT meeting. The completion of this form triggers other processes within the DSR system, including monthly compliance checks and clinical supervision by a senior practitioner.
- That supervision is then itself subject to separate audit by management at service level, with any findings being incorporated into organisational quality reporting to ensure oversight and continuous improvement.
- In light of the evidence heard during the inquest, a formal conversation with all registered professionals will take place at their next clinical supervision session, to reinforce the paramount importance of accurate record-keeping, document management and prioritisation of patient safety at all times.

Concern 3

The MDT made plans for a patient to have drug tests. These were not allocated to an individual to be accountable and were instead allocated to "staff". These tests were not carried out as planned.

Actions taken:

- All clinical tasks are now clearly and unequivocally allocated to a named individual and recorded within the DSR system, to ensure clear accountability and ownership.
- Task completion by the assigned individual is monitored daily during shift handovers by oncoming staff, with any outstanding action either being completed by the incoming staff or escalated to senior management. Ongoing compliance is monitored via monthly handover form audit by a senior practitioner, which also enables early identification of trends and implementation of remedial action where appropriate.

<u>**Leave**</u>

Concern 4

When the responsible clinician was away for an extended period, leave was managed by a non s12 doctor. There is no contemporaneous documentary evidence of the decision-making process by that doctor to reinstate leave as decisions were made outside the formal s17MHA framework.

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Actions taken:

- All clinical decision-making, including that relating to MHA matters, is now documented within each patients' file, both within the DSR system as well as additionally in any relevant minutes – for example within MDT meeting minutes, where a clinical decision has been taken during the course of that meeting.

- Specifically in respect of s.17 MHA decision-making, AFG has updated and reissued to staff guidance as to the process to be followed. In addition, AFG has moved to a system of two leave forms for each patient: one that covers all escorted and emergency arrangements; and a second which covers unescorted leave, to minimise the impact to restriction and recovery.
- To ensure ongoing compliance AFG has introduced regular cross-peer audits of the s.17 leave checklists. The results of the most recent process in March 2026 showed that there were no risks or major issues in any of AFG's other sites.

- This audit process has recently been reviewed by CQC Mental Health Act Inspectors and representatives from Cheshire and Merseyside's ICB at another of AFG's sites, with a positive and fully compliant outcome.

<u>Substance misuse management</u>

Concern 5

On at least one occasion leave was suspended due to suspected drug use but no drug test was taken and no search carried out, and there was no documentation indicating that consideration had been given to undertaking these acts.

Concern 6

On multiple occasions information about recent drug use was not part of the shift handover notes.

Concern 7

Decisions were made to grant unescorted leave to a patient with a known and recent history of cocaine use whilst on unescorted leave, without a full appreciation of their recent substance misuse history.

Concern 8

Information from the patient that he intended to carry on taking cocaine was not handed over to the staff who made the final decisions about leave and checked the patient on return.

Actions taken for Concerns 5 to 8:

- The search policy has been updated and where a search or drug test is required, this is documented within the DSR system. Staff have received refresher training in conducting searches as part of the compliance process, and reminded of the importance of documenting all such actions.

- Staff are required, and have been reminded to record in handover notes and MDT meetings, all material disclosures. To help with this process, the handover template has been reviewed and updated, to ensure it adheres to national standards and guidance. The adequacy of handover notes, and sufficiency of information provided, is reviewed monthly by a senior practitioner, and are also audited by a service's registered manager to ensure appropriate completion and provision of information.

- MDT documentation has been revised and updated to require inclusion of a clear and current risk summary, and staff have been reminded to consider all the patient's documentation including interactions with the patient. The patient's perspective is included as part of the MDT preparation documents.

Documentation

Concern 9

Care plans that should have been in place were either not created at all or were not fully completed.

Actions taken:

- Before a new service user is accepted into a service, an admission care plan is carried out, and this is uploaded to the DSR system. Within 72 hours of admission, the registered manager reviews the admission care plan to ensure that the correct care plan is in place and meets the individual's needs. Following admission and initial review, the DSR system creates a prompt, assigned to a patient's named nurse, to review and where necessary update the care plan on an at least monthly basis. Care plans will also be updated on a shorter timescale if there is a clinical need, for example an adverse event or change in a patient's presentation/ risk profile. Care plan reviews and updates are audited on a monthly basis to ensure continuing compliance, so that any remedial actions can be taken swiftly if required.

- As part of the clinical review process, care plans are audited monthly by a senior practitioner to ensure that the care plan is an accurate representation of the patient's care. If a senior practitioner concludes that the contents of the care plan require improvement, then the senior practitioner will address this directly with the named nurse.

- There is also a clinician-led quality and practice development forum in place to coach and mentor nurses on care plan best practice, which meets monthly.

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Concern 10

The CQC were not notified of periods when the patient went absence without leave.

Actions taken:

- From a regulatory standpoint, AFG is not required to report unauthorised absences of a person liable to be detained under the MHA. Weaver Lodge is not an inpatient unit to which the categories of low, medium or high security applies, as required by Regulation 17(3)(ca) of the Care Quality Commission (Registration) Regulations 2009, and which mandate reporting requirements.

- Following the Inquest, a safeguarding submission was made by AFG to the CQC as regards the general concerns raised at the hearing, and AFG has in addition clarified and reminded all staff of their statutory reporting requirements, including in respect of safeguarding.

Concern 11

Over the course of the inquest there were multiple, serious, disclosure issues relating to non-disclosure of medical records. It appears that at the time medical records were kept across a variety of locations and programmes, electronic and in paper. Staff therefore would not have had a central place to go to find all relevant clinical information about a patient. I am informed that there are plans to implement an electronic record keeping system but I do not have information about the nature, scope or timeframes for this.

Actions taken:

- In response to the Coroner's concern, AFG has reviewed its approach to record collation and disclosure and has taken action to strengthen the consistency and auditability of this process.

- Information relevant to a person's care may legitimately be held across a range of appropriate sources, including DSR, external clinical correspondence, and records held or sent by third parties. Where records are required for an inquest, Subject Access Request, claim, complaint, investigation or other formal request, AFG recognises the value of having a clear process for identifying and bringing together relevant sources.

- AFG has developed a structured Disclosure Control Toolkit and supporting user guide. This provides a stepped governance process for record collation and disclosure, with a nominated lead and defined input from operational, governance, information governance and legal colleagues as appropriate.

- The process is designed to map both work as expected and work as done. It identifies what records should ordinarily exist, where those records are expected to be held, and then records what searches were completed, who completed them, what was found, and whether any limitations require explanation.

- The process also allows relevant custodians to confirm whether, for any reason, potentially relevant information may sit outside the expected record locations. This supports a more complete and transparent search process without relying solely on informal local knowledge or a single system search.

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- The process includes checkpoints before searches begin and before documents are disclosed. This supports source mapping, documented searches, appropriate oversight, quality assurance and proof of service before a response is issued.

- AFG is aligning this process with relevant governance routes, including the Death Review process, so that following a patient death, inquest notification or other formal request, there is a significantly clearer route for identifying, preserving, collating, reviewing and disclosing relevant documentation

- Staff have been reminded that relevant person/patient information, including externally generated clinical documents received by a property, must be recorded, stored and uploaded in line with the expected DSR process.

Quality of investigation

Concern 12

The post event reflective practice report from AFG does not identify any of these issues. The "summary of issues / concerns highlighted" are wholly positive. Post-incident reflection and investigation is an important tool to improve practices and prevent future deaths. Similar concerns about the quality of investigations by AFG were raised in a Regulation 28 report issued by the Manchester City Coroner in 2022 in relation to a death in 2019 (Shona Campbell).

Actions taken:

- The investigation into the death in 2019 was not completed by AFG but provided by a specialist independent, third-party organisation. Whilst in this Regulation 28 report the Coroner suggested that the breadth of the independent investigation missed opportunities for additional learning and practice, the conclusions were wholly accurate.

- All future serious incidents will be reviewed in accordance with PSIRF framework.

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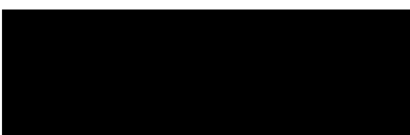
Conclusion

AFG recognises the seriousness of the matters identified and the importance of ensuring that learning is translated into sustained and practical improvement.

The actions outlined above are not limited to Weaver Lodge but are being applied, where appropriate, across all AFG services. Delivery and effectiveness of these actions are subject to ongoing audit, senior management oversight, and reviewed by the Board through AFG's Quality & Safety Committee. This is intended to ensure that improvements are embedded, monitored, and sustained, and that risks are appropriately identified and managed across the organisation.

We trust that this response provides assurance that appropriate action has been taken to address the concerns raised but should further information be required please do not hesitate to contact the Company.

Yours faithfully



Chief Quality & Risk Officer
Alternative Futures Group