MS N J MUNDY
H M CORONER
SOUTH YORKSHIRE (East District)

[redacted]

CORONER'S COURT AND OFFICE
CROWN COURT
COLLEGE ROAD
DONCASTER DN1 3HS

[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted] Chief Executive Officer, Rotherham Doncaster South Humber NHS Foundation Trust

1. CORONER

I am Louise Slater, Area Coroner for the South Yorkshire East District.

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.

http://www.legislation.gov.Uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

3. INVESTIGATION and INQUEST

On 1 September 2025 I commenced an investigation into the death of Delwyn PREECE. The investigation concluded at the end of the inquest .

The conclusion of the inquest was: Suicide.

The cause of death was :

1a Hypoxic brain injury

1b Hanging

4. CIRCUMSTANCES OF THE DEATH

This case relates to the death of a 64 year old man who passed away at Rotherham Hospital on the 19th August 2025, as a result of a hypoxic brain injury following deliberate self suspension by ligature in the grounds of Swallownest Court, an acute mental health hospital in Rotherham.

Mr Preece was admitted as an informal patient on the 2nd December 2024 due to mixed anxiety and depression with associated suicidal ideation. During his admission, there were three recorded incidents where items of clothing were used to fashion ligatures.

Over time Delwyn improved, and he was permitted periods of unescorted leave from the ward. On the 10th of August 2025, Delwyn left the ward in the morning, returning following prompting by staff at lunchtime, then left again and returned later that afternoon.

At approximately 18:20 hours, Delwyn left the ward again. At 19:05 hours, the ward received contact from the police after a member of the public reported finding Delwyn suspended [redacted]. Delwyn was transferred to the Rotherham District General Hospital where he died nine days later.

There was evidence of poor documentation throughout the admission. On a number of occasions, including the 10th August 2025, there is no record to demonstrate that a mental state examination was undertaken or documented prior to leave from the ward being granted.

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 will 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. There were consistent and repeated incidents (13 incidents in 6 days) where leave from the ward was granted without any documented mental state examination or risk assessment being undertaken prior to the patient being permitted to leave the ward.

2. There was poor documentation throughout the medical records with entries lacking detail, being added retrospectively (up to two days later) without any explanation or referencing the retrospective nature of the entry.

3. The Patient Safety Incident Investigation authors were unfamiliar with the medical records system which lead to the retrospective entries not being identified correctly, therefore the investigation did not make any finding. However, with more understanding, it is likely the retrospective entries in the medical records who have been identified and their relevance realised which would have altered the content and findings of the report.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you Mr Lewis 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 **Tuesday the 12th May 2026.** 1, 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: Mr Preece's daughter [redacted]. I have also sent a copy to [redacted] Secretary of State for Health & Social Care.

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.

17 March 2026

Mrs S L Slater Area Coroner

Signature [redacted]

for South Yorkshire East