



Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	<p>REGULATION 28 REPORT TO PREVENT DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1 TEWV</p>
1	<p>CORONER</p> <p>I am Simon CONNOLLY, Assistant Coroner for the coroner area of County Durham and Darlington</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 12/03/2025 11:21an investigation was commenced into the death of Hilary Jane CHAPMAN 18/02/1976. The investigation concluded at the end of the inquest on 05/02/2026 00:00. The conclusion of the inquest was that Hilary Jane Chapman died on 11th March 2025 8:45am at St. Cuthbert's Hospice, County Durham.</p> <p>Hilary suffered from recurrent depressive disorder. She had historically attempted suicide and been detained under section 2 and 3 under the Mental Health Act. Hilary was under section 3 during the events leading up to the cardiac arrest.</p> <p>Based on evidence heard, Hilary's mental health began to decline in September 2024. Hilary was detained under section 2 of the mental health act on 25th November 2024 at West Park Hospital following reports of self-neglect. She was later transferred to Lanchester Road Hospital, on 17th December 2024, onto Tunstall ward. She was detained under section 3 on 20th December 2024.</p> <p>By January 2025, Hilary was self-medicating, and her RC believed she was showing improvement. Hilary was prescribed escorted and accompanied leave which she would take with her sister or friend. Leave was suspended at the end of January due to changes in presentation.</p> <p>On the 18th February 2025, an MDT meeting took place which was attended by Hilary and her sister and other professionals involved in Hilary's care. The prospect of leave was discussed, however the dates of leave were not established in this meeting. After this meeting concluded, the RC spoke to the ward staff and prescribed section 17 leave for daytime unescorted leave from 18th February 2025 at 9am until 10th March 2025 at 9am. He also included overnight unescorted leave the weekend of 22nd February 2025 at 5pm until 24th February 2025 at 12 noon. The dates of this weekend leave were not discussed in the MDT meeting. RC completed Section 17 leave form and this was signed by himself and Hilary. However, Hilary's signature was not dated. The jury also notes that this form was not completed as the form instructs that it is 'given to relevant people including the patient, accompanying person, carer...'. This form was not shared with Hilary's sister who was identified as Hilary's carer.</p> <p>From the 18th February 2025 to the 21st February 2025, Hilary utilised daytime unescorted leave. There was no attempt from the ward to contact Hilary during this leave, despite being stipulated by the section 17 leave form. However, she returned on time each day.</p>



On 22nd February 2025, Hilary asked to utilise section 17 unescorted overnight leave which was approved by the nurse in charge. The nurse in charge asked Hilary what she was going to do and Hilary said she was going to see her sister. She did not have any concerns for Hilary's wellbeing. Jury notes that Hilary was allowed to leave before the stipulated time of 5pm on the section 17 leave form for overnight leave.

Lanchester Road Hospital CCTV and CCTV ANPR show Hilary's following movements. On the 22nd February 2025, Hilary left Lanchester Road at 12:32 after collecting weekend medication from the main reception. She then left Lanchester Road and got into her car. Her car was seen travelling through Durham towards home address noted again to be travelling back through Durham towards Crook. At 13:10, she parked behind the surgery in Crook and walked through to Hope Street. She is seen entering the pharmacy which she had keys to. This pharmacy was Hilary's previous place of work where she was co-owner / director. Hilary came out of the pharmacy 6 minutes later with something unidentifiable in her hand. Her car then drives through Durham city centre at 13:30 back towards home address. CCTV next identifies her car at 17:30 in Durham city centre. The vehicle is noted by Lanchester Road CCTV entering the carpark to the hospital at 17:39, parking up briefly near the main entrance before moving the vehicle out of view from CCTV. There is no further CCTV images of this vehicle or Hilary.

Hilary's phone records show that she received calls from a no-caller-ID at 20:12 on the 22nd February 2025. She received further calls on the 23rd February 2025 at 15:54 and 18:52 and on the 24th February 2025 at 10:35. These calls were not answered by Hilary. The ward attempted to contact Hilary over the weekend, but no contact was made. Nurses on duty did not believe that Hilary's risk had increased on the Saturday. Nurse in charge sought advice of a senior nurse after lack of contact on the Sunday. No action was taken due to Hilary not meeting criteria as a missing patient. An MDT meeting of hospital staff took place on the morning of the 24th February 2024 and still no actions were taken.

At 12:00 on the 24th February 2025, Hilary did not return. This triggered the nurses to act on missing persons procedure. Phone records demonstrate a call from no-caller-ID at 12:19 made to Hilary's phone. This was not connected. Nurse in charge called Hilary's sister to inform her that Hilary had not returned. Sister made them aware that she was not in the Durham area and was on a family holiday in Norfolk and had not spoken to Hilary since Friday 21st February 2025. Her sister said she was unaware that Hilary had been prescribed this weekend leave. Nurse in charge contacted the police and reported Hilary missing at 12:30.

Hilary's sister contacted friends in the area to go to Hilary's home address. They reported Hilary was not there and neither was her car. Hilary's sister rang the ward back and asked them to check the car park. The nurse in charge told the jury that a search of the grounds took place however there was no evidence to support this.

Police officer attended Hilary's home address at 15:00 then went to Lanchester Road Hospital and searched Hilary's room on Tunstall Ward at 16:48. Police noted that Hilary had not left many of her things behind. As the police officer was leaving Lanchester Road Hospital, they identified Hilary's car parked in an area of the car park not covered by CCTV at 17:20.

Hilary was found in the back footwell of her car behind the passenger seat with a blanket over her. Hilary was removed from the car. Nurse in charge was aware that paramedics were on site and were called to the scene. Paramedics arrived and they determined she had experienced cardiac arrest. CPR was administered for 17 minutes until spontaneous circulation was restored. Paramedics also administered adrenaline and a glucose stabiliser. Paramedics noted that Hilary had low body temp (30.4) and low blood sugar (2.2mm/ol).

An undated note was found under the front driver seat which suggested an attempted suicide.



Hilary was taken by ambulance to University Hospital North Durham. Hilary was admitted and a blood sample and urine sample were taken due to suspected overdose. The hospital tested for drugs commonly used in overdoses and the drugs that Hilary was prescribed or had historically overdosed on. No tested drugs were found.

Intensive care consultant asked for bloods to be stored but none were available for further tests. Police failed to request for bloods to be retained.

The ITU consultant noted Hilary to be in a deeply unconscious state with a GCS of 5.

On 28th February Hilary was taken for a second CT scan which confirmed she had a hypoxic brain injury.

Hilary was transferred to a palliative care team and further transferred to St Cuthbert's Hospice on 5th March 2025. Hilary received palliative care and sadly passed away on 11th March at 8:45am. Brother-in-law confirmed Hilary's identity.

Police investigation ruled out any third party involvement in Hilary's death. Evidence demonstrated that Hilary took her own life. Applying the balance of probabilities, evidence suggests that it is probable that Hilary intended to take her own life..

4 CIRCUMSTANCES OF THE DEATH

Hilary was under a section 3 at Lanchester Road Hospital for her depression. Hilary had been out for supervised leave with her sister [REDACTED]. Hilary had then been on unsupervised leave which [REDACTED] was aware of. Hilary went on unsupervised leave and [REDACTED] was not made aware of this. Hilary did not return on the expected time and a search was started. Hilary was found in her own car in the car park at Lanchester Road on 24/2/25. Hilary was found with a suicide note and mixed overdose was presumed cause of cardiac arrest. Hilary was not breathing and did not have a pulse and CPR was started. Hilary had return of circulation from CPR and was transferred to CDDFT ITU where she received care to stabilise her cardiac output. Hilary had a CT head 28/2/25 which showed extensive Hypoxic brain damage and a Best interest decision was done with her sister who felt Hilary would wish for palliative care now. Palliative Care team at CDDFT were involved with discussions around this. Hilary was referred to St Cuthbert's Hospice for end of life care and admitted to the Hospice on 05/03/2025. Hilary was kept comfortable with a syringe driver at the Hospice to manage her secretions. Hilary died on 11/3/25 at 8.45am

All history from sister [REDACTED] and CDDFT Referral letters.

Information From Police

Hilary worked as a Pharmacy Technician at her family pharmacy's in Crook on Hope Street. On 22/02/2025 when the pharmacies are closed, Chapman leaves LRH on her leave. She appears to drive home, then drive through Durham and towards Crook. CCTV shows her parking and walking to one the pharmacy on Hope Street. She had access via keys and knew the alarm code. She is inside (no cctv inside or stocktakes to establish what was taken) for around 6 ins and leaves. She returns home, and travels back in the direction of LRH around 1740hrs on 22/02. She is not seen or heard from again until 24/02 at 1710hrs when found by police slumped in her car in LRH car park away from the building. It appears she may have attended the pharmacy to obtain medication to overdose. Her sister and family were in Norfolk that wkd.

Police Referral

Hilary CHAPMAN was a section 3 patient at Lanchester Road Hospital, and from 18/02/2025 she was allowed unescorted leave under section 17. She has left L.R.H. on 22/02/2025 and was due to return on 24/02/2025. On her failure to return, L.R.H. has alerted Police and her family who have not heard from her. Chapman was found in the rear footwell of her car unconscious following possible overdose. Ambulance attended and CPR was given. Chapman was taken to University Hospital North Durham. A note to her sister [REDACTED] was



	<p>found in her vehicle relating to Hilary's wishes to end her own life. A/DS 2159 Denham will submit an MG11 report in due course as he has dealt with the investigation. It is being deemed as non suspicious and a suicide with no third party involvement. DCI [REDACTED] has been spoken to by A/DS Denham and it is not believed a Home Office Post mortem is required as Hilary was on leave from LRH.</p> <p>TEWV: S.3 MHA was discharged on 6 March due to being on palliate care.</p>
5	<p>CORONER'S CONCERNS</p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows: (brief summary of matters of concern)</p> <p>Tees, Esk and Wear Valley NHS Foundation Trust ("the Trust") gave evidence of policy changes to the way in which section 17 leave was prescribed and also how families were informed and updated of such prescribed leave. The Trust explained the new processes as involving the discussion and agreement of a "Leave Plan" based on the completion of a "Leave Discussion Form" which documents the discussions which have taken place and the terms and conditions of any prescribe leave, with the "Leave Plan" being shared with any person involved in the patient's supervision whilst on leave.</p> <p>Whilst improvements by the Trust to the way in which section 17 leave is discussed, prescribed and shared are acknowledged and welcomed and whilst I acknowledge what I was told about staff training having been undertaken in respect of the new processes, I was concerned that the overarching and updated section 17 leave policy makes no reference to these new processes. I was told that a review of the policy was contemplated although not likely before September 2026. I am concerned at this evidenced gap in Trust policy.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>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.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by April 05, 2026. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons</p> <p>[REDACTED]</p> <p>I have also sent it to</p> <p>[REDACTED]</p> <p>who may find it useful or of interest.</p> <p>I am also under a duty to send a copy of your response to the Chief Coroner and all</p>



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. 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 Dated: 08/02/2026



Simon CONNOLLY
Assistant Coroner for
County Durham and Darlington