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:** **Alternative Futures Group**
1	**CORONER** I am Elizabeth WHEELER, Assistant Coroner for the coroner area of Cheshire
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 01 August 2025 I commenced an investigation into the death of Ruairi Thomas STEWART aged 29. The investigation concluded at the end of the inquest on 20 February 2026. The conclusion of the inquest was: Drug related
4	**CIRCUMSTANCES OF THE DEATH** The jury's findings were: *Mr Stewart died aged 29 on the 31st of July 2025 at Weaver Lodge Independent Hospital in Winsford. At the time of his death he was detained under Section 3 of the Mental Health Act.* *Mr Stewart had a history of substance abuse having taken drugs since 11 years old and [he had been] a regular user of cocaine since 2020.* *He [had] a history of mental health issues and [was] diagnosed as having a schizoaffective disorder and spent time in a secure unit at Bowmere hospital between August 2022 and December 2024. His mental health improved and he was transferred to Weaver Lodge Residential Hospital on the 7th of January 2025 with the aim that upon discharge he would be able to live independently in the community. Upon admission a care plan was agreed.* *Throughout his time at Weaver Lodge, there have been failures to follow policy and procedures, including errors and omissions relating to completion of documents and record keeping on:* • *Shift handover documents* • *Section 17 Care Plans,* • *Section 17 leave of absence documents* • *[One to one] documents* • *Clinical review professionals meeting* *Follow up actions relating to these documents were not completed and there is no evidence of internal audit for compliance of document[s], policies and procedures.* *Communication between nurses, management and clinicians was inadequate, leading to decisions being made with inaccurate or outdated information.*

	Weaver Lodge focused on his mental health, therefore education was provided regarding the risks of the use of illicit substances. *Following a [one to one] meeting with a named nurse and consultation with a registered clinician on 29th of July 2025, there was sufficient information for Section 17 leave to be granted.* *On 30th of July 2025, Mr Stewart had a period of escorted leave and a period of unescorted leave.* *It is probable that Mr Stewart obtained cocaine during this period of unescorted leave.* *Given his presentation on return to the lodge, staff checks were adequate.* *At medical observations at 9PM and general check at midnight Mr Stewart was behaving normally.* *At 2:40 AM on 31st of July 2025, when Mr Stewart went into the garden for a cigarette, staff reported that he was behaving normally. It is probable that Mr Stewart took a fatal dose of cocaine when he returned to his room.* *Mr Stewart was found in his room at 7:45 on the 31st of July 2025 by staff who followed emergency procedures before attention was given by paramedics.* *Mr. Stewart died as a result of fatal cocaine toxicity.*
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: <u>MDTs</u> 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 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 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. <u>Leave</u> 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 s17 MHA framework. <u>Substance misuse management</u> 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. 6. On multiple occasions information about recent drug use was not part of the shift handover notes 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 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 <u>Documentation</u> 9. Care plans that should have been in place were either not created at all or were not fully competed. 10. The CQC were not notified of periods when the patient went absence without leave 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. <u>Quality of investigation</u> 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).
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 May 05, 2026. 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 I have also sent it to 1. Mr Stewart's Family 2. Cheshire and Wirral Partnership NHS FT 3. Care Quality Commission

	who may find it useful or of interest. 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. 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: 10/03/2026** [redacted] **Elizabeth WHEELER** **Assistant Coroner for** **Cheshire**