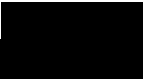
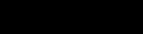
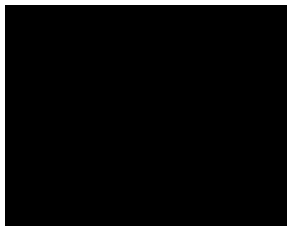


**REPORT TO PREVENT FUTURE DEATHS  
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS  
2013**

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's [PFD Publication Policy \(2026\)](#).

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| 1. | <b>CORONER</b><br>I am Nicholas WALKER, HM Area Coroner, for the coroner area of Hampshire, Portsmouth and Southampton.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| 2. | <b>DATE OF REPORT</b><br>05 August 2026                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| 3. | <b>CORONER'S LEGAL POWERS</b><br>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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 4. | <b>THIS REPORT IS BEING SENT TO</b><br><br>1. Chief Executive Officer, Hampshire and Isle of Wight Healthcare Foundation NHS Trust<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by September 29, 2026. I, the coroner, may extend the period if an appropriate application is made.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 5. | <b>YOUR RESPONSE</b><br>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.<br><br>I have a duty to send a copy of your response to the Chief Coroner.<br><br>In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision.<br><br>Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.<br><br>The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages <a href="#">Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary</a> . |
| 6. | <b>SUMMARY OF CORONER'S CONCERN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

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|     | <p>There is not a clear and understandable policy and guidance framework for the admission of patients and proper risk assessments are not embedded in the practice of some nurses.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| 7.  | <p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 8.  | <p><b>INVESTIGATION AND INQUEST</b></p> <p>An investigation was commenced on 29th November 2021 into the death of Richard Laversuch who was 63 years old when he was unlawfully killed by manual strangulation at Parklands Hospital on 27th November 2021 by a patient, Mr X, who had been incorrectly admitted to an acute ward a few hours previously. A jury concluded that there were failings in the practice of the Approved Mental Health Practitioner used by Hampshire County Council and in the Trust's staff, policies and procedures when admitting Mr X to the hospital.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 9.  | <p><b>CIRCUMSTANCES OF DEATH</b></p> <p>Mr X is a young man who suffered a sudden deterioration in his mental health and was admitted to Parklands Hospital in Basingstoke pursuant to s.2 of the Mental Health Act 1983. He presented a high risk to himself and others and was admitted onto a ward that he was not suited for. Within five hours of his admission, Mr X killed Mr Laversuch and attempted to strangle another patient. The Trust accepted that Mr X had been admitted to the wrong ward and there were failures with respect to communication, decision-making, bed planning prior to Mr X's admission, failures to make appropriate entries on the digital system, failures to risk assess and failures to follow national guidance which more than minimally caused or contributed to death.</p> <p>Mr X pleaded guilty to manslaughter on the grounds of diminished responsibility. An inquest was necessary to consider the wider concerns articulated by the families of Richard Laversuch and Mr X as well as the sentencing judge.</p> |
| 10. | <p><b>CORONER'S CONCERNS</b></p> <p>During the course of the inquest I heard evidence 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 <b>MATTERS OF CONCERN</b> are as follows:</p> <p>I am concerned that five years after the death of Mr Laversuch there is not in place a clear and readily understandable policy framework and guidance for the admission of patients into wards after their detention has been authorised under the Mental Health Act and that there remains, on the evidence heard at</p>                                                                                                                                                                                                                                                                                                                                                                                                          |

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|     | <p>inquest, a failure by some staff to understand what is required of a safe risk assessment. I recognise and accept that there have been efforts to learn from Richard's death and formulate the appropriate guidance, but I am concerned that they are still not clear so long after his death.</p> <p>I am concerned that a patient who poses a significant risk to themselves and others may be admitted to ward unsuited to their risk and that there is a risk of future deaths.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 11. | <p><b>COPIES AND PUBLICATION OF THIS REPORT</b></p> <p>I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it.</p> <p>I also may send a copy of the report to any other person who I believe may find it useful or of interest.</p> <p>I can confirm I have sent the report to:<br/>  of Richard Laversuch<br/>  of Mr X<br/> Hampshire County Council<br/> Hampshire and Isle of Wight Healthcare NHS Trust<br/> The Approved Mental Health Practitioner</p> <p>I also have a duty to send a copy of the report to the Chief Coroner.</p> <p>You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's <a href="#">PFD Publication Policy (2026)</a>. Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.</p> |
| 12. | <p><b>SIGNATURE</b></p> <p></p> <p><b>Nicholas WALKER</b><br/> <b>HM Area Coroner for</b><br/> <b>Hampshire, Portsmouth and Southampton</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |