	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Tees, Esk and Wear Valley NHS Foundation Trust Chief Executive, West Park Hospital, Edward Pease Way, Darlington, DL2 2TS**
1	**CORONER** I am Andrew Tweddle, Senior Coroner, for the Coroner area of County Durham and Darlington.
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. (see attached sheet)
3	**INVESTIGATION and INQUEST** On 8th August 2016 I commenced an investigation into the death of Thomas Whitfield , 62 years old. The investigation concluded at the end of the inquest on 19th April 2017. The conclusion of the inquest was Suicide with a cause of death of 1a) Hanging.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was a voluntary patient at Farnham Ward, Lanchester Road Hospital, Durham, having previously been detained under Section 2 of the Mental Health Act. On the morning of 28th July 2016 there was an incident on the ward which resulted in the deceased being re – assessed by his Consultant Psychiatrist. Within one hour, on a routine observation, the deceased was found hanging in the room. He had not been assessed of been at risk of suicide.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] The deceased's sister made a statement advising that she had spoken to hospital staff alerting them to the risk that she perceived her brother had of suicide. Her statement states that staff had acknowledged this and were aware of this, were monitoring him and they had been able to listen to his telephone conversations which took place near to their desk. Evidence was given that it would be expected that such calls would be recorded in the Paris notes and acted upon including speaking to the patient. A Consultant Psychiatrist gave evidence that if he had been aware of such family concerns it would have affected his risk assessments. There is only one telephone call recorded in the Paris notes which does not make any reference to any such concerns. Many calls now are recorded for monitoring and training purposes and had such calls being so monitored and or recorded then at least it would be possible to prove one way or the other whether such calls had taken place and what their content was. There is no such monitoring or recording of calls at the present time. There is CCTV in the hospital, which can be viewed after an event to clarify what did/not happen.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 15th June 2017. 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 [redacted] Ward Hadaway Solicitors. Care Quality Commission [redacted] 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.
9	**20th April 2017** **[SIGNED BY CORONER]**

A. Wood
HM Senior Coroner.