REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Right Honourable Ben Wallace MP, Secretary of State for Defence**
1	**CORONER** I am Brendan Joseph Allen, Area Coroner, for the Coroner Area of Dorset
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 the 21st March 2018, an investigation was commenced into the death of Alexander Charles George Tostevin, born on the 15th December 1989. The investigation concluded at the end of the Inquest on the 23rd November 2021. The Medical Cause of Death was: [redacted] [redacted] The conclusion of the Inquest recorded that Alexander Charles George Tostevin died by [redacted] in circumstances where there was a missed opportunity to reassess his risk of [redacted] in the light of new information disclosed three days before his death.
4	**CIRCUMSTANCES OF THE DEATH** Corporal Alexander Charles George Tostevin, who passed selection for the Special Boat Service in 2014, died at [redacted] on 18th March 2018, having [redacted]. Corporal Tostevin had been under the care of the Royal Navy Department of Community Mental Health ("DCMH") and the Welfare Team following an incident in September 2017, when he had made unauthorised purchases on a Government Procurement Card while experiencing [redacted] ideation with both a plan and intent to [redacted]. On 13th March 2018,

	Corporal Tostevin suffered a significant deterioration in his mental health, which led to further reviews on 14th March 2018 and 15th March 2018. A risk management plan was formulated on 15th March 2018 that involved a member of the Welfare Team contacting Corporal Tostevin twice a day over the weekend. On 16th March 2018 an email was sent by a Welfare Officer outlining significant disclosures made by Corporal Tostevin the previous day relevant to his risk that were not known by those that assessed him on 14th and 15th March. That email was not seen by the recipients until the following week, leading to a missed opportunity to reassess the risk of [redacted] prior to the weekend.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: 1. During the inquest evidence was heard that: i. The medical care provided to service personnel through the DCMH is not truly independent, in that personal medical information may be disclosed to Chain of Command where substantial public interest demands disclosure, particularly for the protection of the operational capability of the Unit and the safety of other Unit personnel. This is, of course, unlike mental health care provided in a civilian context. The evidence heard at the Inquest was that this lack of independence risks service personnel minimising or under reporting mental health symptoms, including [redacted] thoughts, intent and plans, for fear this would be disclosed to the Chain of Command. ii. Multi-Disciplinary Team meetings are held every 2 weeks at RM Poole, where service personnel who are under the care of the DCMH and/or Welfare Team are discussed. There is also the option for individual Case Conferences to be called on an ad hoc basis to discuss an individual service user if the need arises. Attendees at these meetings include the RSM and/or the Adjutant, DCMH and the Welfare Team. The evidence I heard is that although Welfare Officers are trained to assess the risk a service user may pose to him or herself, in the MDT/Case Conference setting the assessment as to the nature of the risk an individual service user poses, and therefore the risk plan that is formulated to mitigate those risks, is determined only by the view taken by the DCMH. Where a service user may be providing different information to DCMH and Welfare, the true extent of the risk a service user poses to him or herself may not be adequately addressed in the formulation of the risk management plan. iii. There is no single composite risk assessment and care plan for service users that draws together all the relevant information for

	a service user and identifies the plan in place (care plan and risk management plan) at any given time. Such as document is often used in other care settings, including mental health trusts. 2. I have concerns with regard to the following: i. The lack of independence of DCMH risks service users minimising and/or under reporting the risks they may pose to themselves for fear that information may be disclosed to the Chain of Command. If the true extent of the risk of [redacted] is not known by DCMH, an effective risk management plan to mitigate the risk of [redacted] cannot be formulated. ii. The primacy of the view of DCMH when considering the risk of [redacted] in MDT/Case Conferences again means that the true risk of [redacted] may not be accounted for, particularly where a service user is providing different information to DCMH and Welfare and/or where there is a disagreement between DCMH and Welfare as to the presenting level of risk. Adopting a process similar to a Multi-Agency Risk Management Meeting ("MARM") or Multi Agency Risk Assessment Conference ("MARAC") in a civilian context may assist: in a MARM or MARAC, the level of risk adopted is the highest level raised in the meeting/conference, without any agency having primacy. Therefore, the risk management plan subsequently formulated addresses the highest level of risk brought to the meeting. iii. Where there is no composite risk assessment and care plan document that draws together all the relevant information for a patient and identifies the plan in place at any given time, there is a risk that key information and risk factors are missed, which is less likely if there is a composite document in addition to the clinical records.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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, 1st February 2022. 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: (1) Hodge, Jones and Allen Solicitors, representing the Corporal Tostevin's family; (2) Government Legal Department, representing the MoD; (3) Government Legal Department, representing W1, Corporal Tostevin's allocated Welfare Officer. 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	**Dated** 6th December 2021	**Signed** **Brendan J Allen**