ANNEX A

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:** **South Essex Mental Health Partnership Trust**
1	**CORONER** I am Mrs Caroline Beasley-Murray, HM SENIOR Coroner, for the area of Essex
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 21st May 2015 I commenced an investigation into the death of David John Pooley. The investigation concluded at the end of the inquest on 30th October 2015. The cause of death was 1a) Hanging. The conclusion of the inquest was a Narrative Conclusion;- David Pooley killed himself whilst suffering from depression. David John Pooley's risk of self harm/suicide was not properly and adequately assessed and reviewed.
4	**CIRCUMSTANCES OF THE DEATH** Mr Pooley who was 66 years old, was admitted to Basildon Hospital on the 5th May 2015 following an attempt to hang himself in his own home. He spent time in the Mental Health Assessment Unit and he was then transferred to Gloucester Ward. He was found hanging in the toilet on the ward and his death was confirmed at 6:38am on the 20th May 2015.
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. – 1. Contrary to the trust's policy, there was no named nurse allocated until the day before Mr Pooley's death. The role of the named nurse had not therefore been carried out – this entails the devising of a risk assessment, care plans, one to ones, contact with the patient's family etc. 2. The appropriate assessments and reviews were therefore not carried out.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 January 2016. 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. **Mr Pooley's Family.** 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	**3rd November 2015** **Mrs Caroline Beasley-Murray**