REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Chief Constable Essex Police and National Police Chiefs Council**
1	**CORONER** I am Area Coroner for 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** On 10th September 2021 I commenced and concluded an inquest into the death of Anthony James Preston
4	**CIRCUMSTANCES OF THE DEATH** Anthony James Preston died on the 16th November 2020 at his home address of ████ ██████████, Waltham Abbey as a result of suspension by Ligature. He was known to Mental Services and a Serious Incident Report was undertaken by EPUT. On the evening of the 15th of November 2020, the police attended Mr Preston's home following a concern raised by a friend. Mr Preston let them in but was naked, with lacerations to his wrists and was under the influence of alcohol. He had laid out clothes for his casket and written four notes to his family. He told the police he had attempted to hang himself, but it had gone wrong. An Ambulance was called and Mr Preston agreed to attend A&E. As Mr Preston agreed to go to A & E and was in a private place so the was not detained under the Mental Heath Act and they did not escort him to hospital. They were however aware of the severity of his condition at that time. On arrival, basic medical checks were completed and a referral for a mental health assessment was made. However, before the assessment took place Mr Preston was noticed to be missing from his cubicle. When he could not be found the police were informed. The Mental Health Liaison Team notified his community team of his attendance at A&E and the circumstances of his disappearance. This was followed up straight away the following day and after failure to contact Mr Preston by telephone his support worker and the stand in Care Coordinator called at his home address at 10:30am. After they received no response the police were called and Mr Preston was subsequently found deceased within the property suspended by a ligature.
5	**<u>CORONER'S CONCERNS</u>**

	During the course of the inquest, it revealed matters giving rise to concern. The matter had already been referred to the IOPC. That investigation gave no concerns around the inactions of Essex Police. This causes me great concern. The LPT inspector on duty the 15th November 2020 into 16th November 2020 when the police attended the home address of Mr Preston, received the information from Princess Alexander Hospital that he had absconded, the information was given to him around the circumstances of his attendance at A & E and it is my opinion and on the evidence during the inquest, that he should have been treated as a high-risk missing person, which did not happen in this case. The Inspector referred to anecdotal and personal experience of Princess Alexander Hospital and refused to send police out to look for him unless the hospital sent an ambulance around to his Home Address first, the hospital would not do this and said it was a police matter. The incident was closed on the police records. When the Mental Health team arrived at Mr Preston's home address the morning of the 16th November 2020, they had no right of entry and phoned the police again. When the police attended, Mr Preston was found suspended. 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. – That the Police Missing Person Policy should be looked at to see if it is fit for purpose.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you 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 22nd November 2021 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 who may find it useful or of interest. 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	**Date. 23rd September 2021** **Name Michelle Brown** **Area Coroner Essex**