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:** NHS England Swift House Hedgerows Business Park Swift House Colchester Road Springfield Chelmsford CM2 5PW Essex Partnership University Trust Head Office The Lodge Lodge Approach Wickford Essex SS11 7XX
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**
4	**CIRCUMSTANCES OF THE DEATH** Jan Goodliffe died on 15th June 2021 at an address where he worked in Rochford Essex due to [redacted]. He had a long history of Mental Health problems during his life and had periods as an inpatient during his life. A few days prior to his death, he had tried to [redacted] himself, but a family member had found him and prevented anything happening. Mr Goodliffe lived with his wife and was consistently expressing views around him wishing to take his own life. He was visited by clinicians prior to his death, who were not medically qualified, yet deemed him not at risk of suicide, despite his wife expressing concerns and telling them that he had taken medication to calm himself down prior to their arrival and setting out his attempt to take his own life a short while prior. It was also in evidence that Mr Goodliffe had been prescribed medication by his psychiatrist in March of 2021, however, there appears to be an issue with how these to be on repeat prescription, evidence showed that [redacted] was potentially meant to reorder these, and a mistake occurred which meant he went without this medication for Bi Polar for the month of May 2021. It was communicated to the clinicians that attended to see Mr Goodliffe of his apparent decline without the medication for the month period (he had at that appointment restarted this medication) However when he had been first prescribed this medication, he was an inpatient and the trust extended his inpatient stay to ensure the medication was working correctly. All this was communicated to the clinicians at the home appointment. Several days later Mr Goodliffe took his own life.
5	**CORONER'S CONCERNS**

	During the course of the inquest, it 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. – That the Clinicians who attended to assess Mr Goodliffe where not medically qualified, they were social workers. They were presented with evidence around a serious attempt by Mr Goodliffe to take his own life that he had to be cut down by a family member. [redacted] gave all this information at the assessment along with the recent reintroduction of the Bi Polar medication, and the facts of the previous reintroduction when starting his medication and the time taken for this medication to start to work. As they were unqualified medical practitioners, there were missed opportunities to seek qualified medical advice around the interactions of the medication and whether as a result of this contributed to his death. I am concerned that suitably medically qualified clinicians are not being used in the home assessments and decisions are being made around issues that require medical expertise.
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, 11th March 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 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. 14th January 2022** **Name** **Michelle Brown** **HM Area Coroner Essex - OBE**