xREGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Chief Executive Officer of Essex Partnership NHS Trust, [redacted],** *Essex Partnership University NHS Foundation Trust, The Lodge, Lodge Approach, Runwell, Wickford, SS11 7XX*
1	**CORONER** I am Sean Horstead, Area Coroner, for the coroner 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 6th August 2021 I commenced an investigation into the death of Stephanie Moyce, aged 55 years. The investigation concluded at the end of the inquest on the 23rd February 2022. The conclusion of the inquest was one of suicide, with a medical cause of death of '1a Fatal pressure on neck'.
4	**CIRCUMSTANCES OF THE DEATH** Ms Moyce, a Registered Mental Nurse with 25 years' experience working for EPUT as an RMN before retiring in 2010, had a lengthy history of mental health issues with episodes of depression from 1990 and a diagnosis of bi-polar disorder in December 2006; she also had a history of alcohol misuse. Ms Moyce had a documented history of repeated drug overdoses dating back to 2000 and in the seven years or so preceding her death (and prior to that) she had been hospitalised following impulsive suicide attempts including: an overdose of prescription medication leading to hospitalisation for a week in 2015; cutting her throat and wrists requiring multiple stiches in 2018; repeated attempts to hang herself over the course of a weekend in 2019. She was lasted detained under Section 3 of the Mental Health Act 1983 in October 2014 and had been subject to Section 117 MHA after care since then, under the care of the Essex University Partnership NHS Foundation Trust (EPUT). Ms Moyce also suffered from a number of complicated physical health complaints, including the sequalae to a badly broken leg, and received regular, funded Carer Support arising from her myriad physical health and mobility issues. In November 2019 Ms Moyce was referred by her then EPUT Care Coordinator to the EPUT Psychotherapy Service in November 2019. She started therapy in May 2020, and this continued until 9th June 2021. When referred to and accepted by the Psychotherapy Services her therapist became her Lead Clinician and, the evidence established, she no

	longer had an EPUT Care Coordinator. Ms Moyce had last had contact with a Care Coordinator in November 2019. At the conclusion of the therapy no new Care Coordinator was identified. Following the last session with the psychotherapist Ms Moyce was discharged from the Psychotherapy Department back to the care of her GP. The therapist gave evidence to the effect that upon this discharge back to the GP Ms Moyce was, to the therapist's understanding, discharged from EPUT and confirmed that she made no further plans or arrangements with respect to Ms Moyce's care, monitoring, safe-guarding or follow up of any kind whatsoever (save to confirm that should she wish to return for further therapy she could do after six months had elapsed – coincidentally around the period of the next scheduled annual Section 117 review). Evidence called at the inquest established that, notwithstanding the fact that Ms Moyce had been and continued to remain subject to the provisions of Section 117 and under the care of EPUT there was: (a) no identifiable person responsible for her on-going care provision; (b) her case had not been discussed at an MDT meeting prior to or following her discharge from the psychotherapy; (c) no safety-netting or further care planning of any kind was arranged prior to or following the discharge from therapy. Whilst an annual Section 117 review would have been scheduled for the following December no plans for any other active/ proactive involvement with Ms Moyce of any kind had been identified by EPUT practitioners. Further, her partner and main carer had not received, as it was accepted in evidence he should have, a 'Carer's Review' since 2016. Additionally, and notwithstanding the myriad suicide attempts referred to above, her partner and main carer had not been invited to contribute to Ms Moyce's Section 117 review in December 2020 contrary to paragraph 8 of EPUT's own *'Pan Essex Section 117 MHA1983 Protocol'*. On 30th July 2021, Ms Moyce took her own life by [redacted]; she was discovered by her partner.
5	**CORONER'S CONCERNS** During 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. Evidence confirmed a conspicuous lack of clarity as to who, amongst EPUT clinicians/staff, is responsible for ensuring that a clear and comprehensive discharge plan is formulated for those *coming to the end* of a course of psychotherapy where a Care Coordinator is no longer in place/has not been replaced; 2. Evidence confirmed a conspicuous lack of clarity as to who, amongst EPUT clinicians/staff has the responsibility for oversight of patient care *following* discharge, including responsibility for ensuring adequate and appropriate safety-netting is in place in the event of relapse, where a Care Coordinator is no longer in place/has not been replaced; 3. Evidence confirmed that patients under psychotherapy are not presently routinely discussed in the locality multi-disciplinary team meetings prior to their

	discharge leading to a missed opportunity: (a) to share information about the specific progress, vulnerabilities and risks of relapse of the patient (and measures to mitigate or deal with the same); as well as (b) to organise and follow up the overall discharge planning. 4. The evidence in this case indicated that, contrary to EPUT's own established Protocol, a patient's carer (in this case her long-term partner where no confidentiality issues were identified) are not in practice always *"seen as equal partners in the development and review of Section 117 after-care plans"* and involved directly in such reviews.
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 22.04.2022. 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: [redacted], partner of the deceased. 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	 **HM Area Coroner for Essex Sean Horstead** **25.02.2022**