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. [redacted], CEO, Essex Partnership NHS Foundation Trust** **2. [redacted] - Essex County Council**
1	**CORONER** I am Sonia Hayes, 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 27 October 2020 an investigation was commenced into the death of Molly Ann SERGEANT, aged 17 years. Molly Ann Sergeant died on the 16 October 2020. The investigation concluded at the end of the 5-day inquest on 7 December 2022. The conclusion of the inquest was Narrative with a medical cause of death of '1a Hanging
4	**CIRCUMSTANCES OF THE DEATH** Molly-Ann Sergeant was found deceased on 16 October 2020 hanged [redacted] in Woodlands [redacted] with the intention of ending her life and left a note. Molly was treated for depression and had a history of chronic self-harm that had required a prolonged hospital admission at St Aubyn's under the Mental Health Act and did not accept her diagnosis with Autistic Spectrum Disorder. Molly was discharged on 17 August 2020 following phased community leave with a plan in place for her mental health. Confusion between different statutory provisions led to her case being closed to social care and, significant delays in this case being reopened. Molly was allocated a social worker five weeks after her discharge for

	an assessment that was ongoing. Molly attended her Care Programme Approach meeting on 9th October 2020 and left distressed. Suicide - Social care failed to carry out appropriate requested assessments during Molly's prolonged hospital admission and there was not a coherent co-ordinated approach to meeting Molly's social aftercare needs. Molly's right to aftercare services was recorded but the functions were not discharged as they should have been during her admission, and this contributed to her death.
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) Molly had a delayed diagnosis of Autism. Molly was diagnosed during her detention at the St. Aubyn Centre when she experienced a mental health crisis and detained under the Mental Health Act. (2) There was insufficient assessment for discharge planning purposes of the impact of Molly's recent diagnosis of Autism by Essex Partnership NHS Foundation Trust (3) There was insufficient consideration given to the impact of Molly's delayed diagnosis of Autism on her chronic high risk of suicide in her discharge and discharge planning in a background of Molly not accepting her diagnosis. (4) Lack of escalation to Essex County Council when there was a failure to respond to requests for assessment and attendance at discharge planning meetings and the key worker/care co-ordinator carrying too heavy a workload as a consequence. (5) Essex County Council did not: a. act on appropriate referrals to social care by Essex Partnership NHS Trust b. conduct required assessments of Molly during her detention c. did not appoint a social worker until after Molly was discharged

	There was a lack of understanding of the impact of Molly's detention on her right to assessment as a child in need and how this changed during her detention under the Mental Health Act. (6) A lack of understanding of section 117 Mental Health Act rights and potential for consideration for entitlements to meet Molly's needs related to her mental health disorder, by Essex County Council: a. compelling Molly to choose between family members as part of her discharge planning and then as a consequence changing Molly's status during her detention from homeless. b. Lack of assessment for any s117 needs to facilitate discharge c. Lack of appreciation of the impact of Molly's autism diagnosis in a background of chronic suicide risk on decision-making and Molly's potential to understand the decisions being made.
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 7 April 2023. 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] [redacted] (Parents) • [redacted] (Grandmother) • Care Quality Commission 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	 **19.02.2023** **HM Area Coroner for Essex Sonia Hayes**