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**
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 9 June 2022 an investigation was commenced into the death of Bency JOSEPH, aged 43 years. Bency Joseph died on the 27 May 2022. The investigation concluded at the inquest on 4 April 2023. The conclusion of the inquest was a Narrative: There was delay in the provision of antipsychotic and anxiolytic medications to Bency Joseph during a four-day period in 24-27 May 2022 and this contributed to her death during a severe psychotic episode with a medical cause of death of '1a Traumatic head injury, 1b Fall from height.
4	**CIRCUMSTANCES OF THE DEATH** Bency Joseph died instantly on 27 May 2022 from Traumatic Head Injury following a headfirst fall from an upstairs window at home, she did not have the capacity to formulate an intention to take her own life. Bency Joseph had been suffering with recent mental health issues and attended Broomfield Accident & Emergency Department on 24 May with acute psychotic presentation and assessed as not having capacity. Bency Joseph underwent Mental Health Act assessment on 25 May and referred to the Home Treatment Team and the First Episode Psychosis Team. Bency Joseph was reviewed on 26 May and prescribed urgent medication by the community psychiatrist for a severe psychotic episode and was responding to unseen stimuli and was assessed as not having capacity. Bency Joseph's mental health deteriorated further at home.

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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) Essex Partnership NHS Foundation Trust Mental Health Liaison Psychiatrist assessed Bency Joseph as suffering from a first episode psychosis when she attended hospital on 23rd May as an emergency and there was a delay in prescribing and administering therapeutic medication required for a first episode of psychosis with delusions.

a. [redacted] Lorazepam was prescribed and administered on 25 May 2022 at hospital and evidence was that this was sub-therapeutic. One dose of medication was administered and Bency Joseph was discharged under the care of the Home Treatment Team.
b. On 26 May the Home Treatment Team consultant psychiatrist found that Bency Joseph did not have capacity, had deteriorated and prescribed urgent medication to be provided on the same day. The medication was not provided.
c. It is unclear if the urgent prescription was received and processed.
d. The Family's concerns and attempts to escalate the failure to provide the medication were not actioned by the Trust and the death occurred in the early morning of 27 May as the Family were making arrangements to take Bency Joseph back to accident and emergency due to the omission to provide medication and further deterioration.

(2) The Trust investigation did not:

a. Inform or involve the Trust Senior Pharmacist who was unaware of the death and had no opportunity to be involved in the internal investigation.
b. Involve the Family of the deceased
c. Lost an opportunity to understand concerns that the Family had been trying to access additional urgent medication prescribed on 26 May 2022 without success and had been telephoning the Trust to raise an alert.

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 July 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] (Husband) • 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	S. M. Hayes **07.05.2023** **HM Area Coroner for Essex Sonia Hayes**