REGULATION 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, Paul Scott,** *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 15th June 2021 I commenced an investigation into the death of Johanne Blackwood, aged 55 years. The investigation concluded at the end of the inquest on the 11th May 2023. Johanne Blackwood (known as Jo) died on the 12th of June 2021 when she placed herself in the path of a train [redacted] The medical cause of death was confirmed as '1a Multiple traumatic injuries', 1b 'Collision with train (locomotive). In a narrative conclusion I recorded that the deceased took her own life on a background of diagnoses of severe and long-standing mental health disorders including Persistent Delusional Disorder, Mixed Anxiety and Depressive Disorder and Panic Disorder. I concluded, *inter alia*, that an inappropriate over-reliance upon family members to keep a vulnerable and high-risk person safe in the community, over an extended period, probably contributed to Jo taking her own life.
4	**CIRCUMSTANCES OF THE DEATH** A central aspect of Jo's delusional beliefs was that (a) she had not slept for years and (b) that she suffered from a fatal physical health condition. The desperation engendered by her delusional and medically entirely unfounded beliefs led to a number of suicide attempts and both voluntary and compulsory admissions to mental health units. On the 1st May 2021 Jo had attempted suicide [redacted], some five weeks later, she

would end her life. In the light of this incident her community risk assessment, her care plan and her safety plan were not up-dated – as they had not been since the date of her last discharge as a mental health in-patient on the 18th December 2020.

Whilst her high risk of suicide was acknowledged by the community mental health team responsible for her safety - and care, management and treatment - in the community, and notwithstanding the context of the Covid-19 pandemic, I found an inappropriate over-reliance upon her family members, principally her husband and son, to keep Jo safe in the community. This involved the family monitoring Jo 24 hours a day, seven days a week over an extended period and physically preventing her from leaving her home address unaccompanied.

This over-reliance was misguided and placed an unfair and unsustainable burden on the family, particularly in the light of a highly concerning text message sent by Jo to her Care Coordinator threatening suicide on the 11th June, the day before she took her own life. Following receipt of the text and seemingly reassured in part by Jo's apparent retraction of the threat later that day, there was a failure to undertake an urgent face to face assessment by the community team to establish whether a referral to the Crisis Team was necessary; this specific failure possibly contributed to the subsequent death.

In the circumstances I concluded that an inappropriate over-reliance upon family members to keep such a vulnerable and high-risk person safe in the community, over an extended period of time, probably contributed to Jo taking her own life on the 12th June 2021.

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CORONER'S CONCERNS

During the inquest the evidence revealed matters giving rise to concern. Although not identified as causative of the death in this case, 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 when, where and by (or between) whom any formal handover of responsibility as Care Coordinator (CC) for Jo took place as between a number of CCs allocated to Jo over a period of many months* from the lead up to and following her discharge as an in-patient back to the community team on December 18th 2020 and through to early May 2021.

2. Consequently , the evidence confirmed, despite her clear vulnerabilities, Jo did not have an allocated Care Coordinator for several weeks up to the beginning of May 2021. The evidence also confirmed that the lack of clarity as to the timing and conduct of CC handovers and the absence of an allocated CC to work with Jo (and by extension, her family) was informed by *lack of a formal policy or procedure requiring that a full, detailed, formal record of handover between Care Coordinators is to be placed on EPUT electronic records.*

3. 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. ***Please note that this 3rd concern was previously raised by me with [redacted] CEO of EPUT (and in very similar terms) in a PFDR dated 25.02.2022 following the death of Stephanie Moyce.*** 4. The community Risk Assessment, Care Plan and Security Plan for Jo were not updated by a Care Coordinator between December 2020 and Jo's death.
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 Thursday 21 September 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], son of the deceased, Fosters Solicitors, the lawyers representing [redacted] and other members of the deceased's family including her partner and parents. 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** **27.07.2023**