REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **[redacted] – CEO** **Essex Partnership University Trust** **The Lodge, Lodge Approach** **Wickford, Essex, SS11 7XX**
1	**CORONER** I am Stephen Simblet KC, assistant 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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 26 October 2022 I commenced an investigation into the death of KATHARINE ANNE FOX, aged 51. The investigation concluded at the end of the inquest on 1st December 2023. The conclusion of the inquest was that the deceased had died from hanging, and the conclusion was suicide.
4	**CIRCUMSTANCES OF THE DEATH** Katharine Fox was being treated at home following a stay as an in-patient in Broomfield Hospital. Some of that stay had involved the deceased being detained under section 2 Mental Health Act 1983. While being treated in hospital, the deceased obtained psychology treatment in the form of a series of sessions with a trainee psychologist with whom she built a good clinical relationship and from which she reported benefiting significantly. Following her discharge from hospital, this psychology treatment effectively came to an end, since the procedures for receiving this treatment in the community were passed to an entirely separate set of clinicians. There was an entirely separate procedure for referral and provision of psychology sessions, with a very significant wait, and the deceased never in fact secured access to those services in the months between being discharged (in May 2022) and her death in October 2022. I was also told by the witness conducting EPUT's own investigation that the teams use separate notes, and it may not always be possible for those notes to be accessed by other teams. This included evidence that a different computer system is used in the north of the county from in the south.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) I am concerned that the disconnection between the provision of psychology services to patients in hospital and the provision of similar psychology services to patients in the community, including the fact that the community psychology service does not receive any form of handover and that there is a substantial wait for the provision of psychology sessions which may well require continuity to be delivered effectively. (2) I am concerned about the fact, if that is indeed right, that some clinicians in the

	psychology service may not be able to access notes made by clinicians in either other hospitals or other parts of the county. I was told that had the deceased actually managed to procure psychology sessions that the new psychologist may not have been able to read the notes of their predecessor if they were on a different computer system.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 3rd February 2024. 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: (1) [redacted] (2) EPUT - The Lodge, Lodge Approach, Wickford, Essex, SS11 7XX 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	**7th December 2023** **Stephen Simblet – Assistant Coroner**