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 13 September 2022 an investigation was commenced into the death of Georgia Gypsy Catherine Dehaney-Perkins aged 36 years. Georgia Dehaney-Perkins died on the 6 September 2022. The investigation concluded at the end of the inquest on 6 December 2023. The conclusion of the inquest was Narrative 'Ms Dehaney-Perkins consumed prescription medication and alcohol and had been previously found at the same location when she went missing. It is not possible to determine if Ms Dehaney-Perkins intended the outcome to be fatal' with a medical cause of death of '1a a Combined Alcohol and Drug Toxicity ([redacted])
4	CIRCUMSTANCES OF THE DEATH Georgia Dehaney-Perkins was found deceased on 6 September 2022 on Latton Common, Harlow by her family who had reported her missing that morning and gave this as the last known location of Georgia. Police did not attend Georgia's home address and downgraded her from a missing person to a concern and did not inform the family of the decision. Ms Dehaney-Perkins sought medical assistance when she began to struggle with her mental health and following a misdiagnosis of cancer. Ms Dehaney-Perkins had a known history of self-harm, suicidal ideation and being found as an at-risk missing person with inpatient admissions for care and treatment due to her deteriorating mental health. Ms Dehaney-Perkins' recent overdose of medication required admission to hospital

	as she could not keep herself safe. Ms Dehaney-Perkins attempted to hang herself on 28 August whilst in her bathroom on the ward. Ms Dehaney-Perkins was discharged on 2 September 2022 with 14 days' supply of her medication. A 24-hour follow-up call had not been made by mental health services. The Home First Treatment Team assessed Ms Dehaney-Perkins on 4 September at home and transferred her care back to her care co-ordinator. Ms Dehaney-Perkins was suffering from mental health disorder with features of self-harm that elevated when she consumed alcohol. Ms Dehaney-Perkins' father contacted the Home First Treatment Team on the evening of 4 September asking if they had attended that day and informed the nurse that he understood that Ms Dehaney-Perkins had consumed alcohol, police had attended, and she left home with her medication. The Home First Treatment Team nurse did not attempt to contact Ms Dehaney Perkins, her partner or the police. Ms Dehaney-Perkins died due to Combined Alcohol and Drug Toxicity ([redacted]) that interacted to increase sedation and cardiac arrhythmia causing death.
5	**<u>CORONER'S CONCERNS</u>** 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) On 28 August Ms Dehaney-Perkins was agitated and distressed on return to the ward from leave and had consumed alcohol that was known to increase her risk of self-harm. [redacted]. Staff found Ms Dehaney-Perkins and removed the ligature. a. Ms Dehaney-Perkins was admitted to a room with an assisted bathroom (this was not a requirement for her) with a fault in the anti-ligature safety mechanism meant that the safety feature could not be implemented. b. There was no risk assessment about the suitability of this room for Ms Dehaney-Perkins a patient with a self-harming history at the time of the admission. c. The fixed-point ligature was not appropriately updated in the risk assessment and was not discussed at a discharge planning meeting. d. The Trust Datix Report was incomplete (2) Medication was appropriately withheld on 28 August when Ms Dehaney-Perkins returned to the ward intoxicated due to potential interaction with alcohol that can cause increased sedation, (3) arrhythmia and fatality. a. This risk of consuming alcohol with her specific medication was not

	discussed with the Ms Dehaney-Perkins or family. b. Not all incidents of consumption of alcohol on return from leave were recorded and risk assessments were not updated. c. Ms Dehaney-Perkins had agreed to mitigations of medication management by her family that were not recorded on the care plan on discharge on 2 September. Ms Dehaney-Perkins demanded control of her medication on 4 September against concerns of her family who were forced to return medication. (4) The Home First Treatment Team attended a scheduled appointment on 4 September and Ms Dehaney-Perkins appeared stable and updated the risk assessment that the risk of self-harm remained significant when alcohol was consumed. No action was taken following a call raising some queries and concerns from family that evening that Ms Dehaney-Perkins had left her home with her medication.
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 31 March 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: • The family of Ms Dehaney-Perkins • Hertfordshire Partnership University NHS Trust I am also under a duty to send the Chief Coroner a copy of your response. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	 **05.02.2024** **HM Area Coroner for Essex Sonia Hayes**