	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], Chief Executive, South London and Maudsley NHS Foundation Trust, Maudsley Hospital, Denmark Hill, London, SE5 8AZ 2. Rt. Hon Victoria Atkins MP, Secretary of State for Health and Social Care, The Department for Health and Social Care, 39 Victoria Street, London SW1H 0EU 3. NHS England [redacted]
1	**CORONER** I am Xavier Mooyaart, an assistant coroner for the coroner area of Inner South London.
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 27/11/2020 an investigation commenced into the death of Jada Monoja, a 33 year old man who died from a self-inflicted knife wound. His inquest was concluded on 23 April 2024. The conclusion of the inquest was that Mr Monoja died by suicide likely while experiencing delusional and paranoid thoughts.
4	**CIRCUMSTANCES OF THE DEATH** Mr Monoja had a history of chronic paranoid and delusional thinking. On 15 November 2020 his mother contacted 111 after he disclosed suicidal thinking to her. This was rapidly escalated to mental health services and that evening a member of the Crisis Assessment Team (CAT) assessed Mr Monoja. He denied remaining suicidal, agreed to treatment and was assessed to have capacity. He was referred to the Home Treatment Team (HTT). On 16 November 2020 Mr Monoja was assessed and accepted by the HTT and a care plan agreed. In the early hours of 17 November 2020, his mother woke and found Mr Monoja had left their home. She found him nearby on Cleaver Square, unresponsive. Emergency Services attended but he could not be resuscitated. At home he had left notes of farewell.

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. – Multiple witnesses indicated that the Risk Assessment Tool on the online system (EPJS) is not used in line with policy (i.e. that a new assessment in that tool is undertaken at the time of each admission/discharge/major risk event etc.), and, if updated, may only be updated in so far as additional narrative is added to the last such narrative in a previously completed assessment. Further, the evidence was that rather than be used for a detailed assessment per the indicators set out in the tool at the time of each relevant event, it was reviewed to instead access any past assessment in order (only) to establish quickly a benchmark against which the gauge a patient's current presentation when considering their risks. The detailed indicators informing the risk assessment were not updated. Although it was submitted that patient risk was nonetheless assessed and recorded in the EPJS, and acknowledged that benchmarking/comparison is useful, I am concerned that: (1) if the risk indicators set out in the tool are not systematically reviewed or reconsidered, then the assessment of risk that follows will then be based on incomplete, and therefore misleading, information; and (2) absent the above, and dating of revisions within a compound document, it is not clear on what indicators any assessment is in fact based (3) to the extent the risk assessment is used as a benchmarking tool, the impression given to the most recent viewer is then likely to be incomplete and misleading; (4) the apparent current use of the tool to establish a point of benchmarking/comparison is in any event lost where the compound narrative assessments are not clearly dated and signposted ; (5) if the detailed patient assessment is instead placed as a new entry in the general chronological notes, the usefulness of the tool as a clear, well signposted, dated assessment and documentation of the patients of risk(s), is lost, requiring a reviewer to instead review the general chronological log of entries on the EPJS where it is not required to be articulated in the same terms, and may be more difficult to identify in a longstanding patient.
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 Monday, 8th July 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 family, as the other Interested Person in this inquest. I have also sent it to Oxleas who may find it useful or of interest, as the other major provider of mental health services in this jurisdictional area. 1. [redacted] for Family [redacted] (NOK) 2. [redacted], Chief Executive, Oxleas NHS Trust 3. Chief Coroner @ Regulation28reports@judiciary.uk I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other 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.
9	**[DATE]** **[SIGNED BY CORONER]** Amended Thursday 23rd May 2024 Mr Xavier Mooyaart