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. Chief Executive Officer Mid & South Essex NHS Foundation Trust** **2. Chief Executive Officer Essex Partnership University NHS Trust** **3. NHS England**
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 25 February 2022 an investigation was commenced into the death of Aaron James DEELEY, AGE 43. The investigation concluded at the end of the inquest on 24 May 2024. The Jury's conclusion of the inquest was 1a Multiple Traumatic Injuries with a Narrative: Aaron James Deeley came to his death by suicide contributed to by neglect on the 14th January 2022 at 01:58.We accept the admissions made by Mid and South Essex NHS Foundation Trust (MSE) as attached. However, in addition we consider probable, causative factors as follows; MSE had ample opportunities to make good or replace the windows, as the issues were first reported in April 2019 but had failed to do so by the time of Aarons' death. Notwithstanding a Section 5(2) of the Mental Health Act, Deprivation of Liberty Safeguards (DOLS) and Mental Capacity Act paperwork being in place, the security one to one (1:1) was removed, failing to meet Aarons' requirements for ongoing 1:1 supervision at circa 21:00 on 13/01/2022. In addition, we consider the following possible causative factors as follows; Insufficient administration and inadequate record keeping, incidents of these failures include: - Inconsistencies in completion of the ward Enhanced Observation Form

	on 13/01/2022, - Following Aarons' first suicide attempt the discharge paperwork of the Mental Health Liaison Team (MHLT) assessment on 02/12/2021 was sent to the wrong GP address, - Discharge paperwork from Southend Hospital on 02/12/2021 was lacking sufficient detail of the intent and the overdose medication, - Insufficient minutes recorded from the Essex University Partnership NHS Foundation Trust (EPUT) Multi-Disciplinary Team (MDT) on 21/12/2021, to understand the decision to decline the referral of Aaron to the First Response Team, - On-going COVID restrictions impacting staffing and working environment during November 2021 to January 2022, - Conflicting understanding of the policy regarding the intervention of the MHLT for patients on the Acute Medical Unit (AMU) ward.
4	**CIRCUMSTANCES OF THE DEATH** Following several known suicide attempts, over the period November 2021 and January 2022, failings in the care and safeguarding provided by Mid and South Essex NHS Foundation Trust contributed to Aaron James Deeley being able to take his own life. On the 14th January 2022 at around 01:26 Aaron James Deeley took deliberate action to exit from the defective 2nd floor window next to his bed on Acute Medical Unit 1 ward at Southend Hospital. Landing on the ground below, Aaron sustained multiple traumatic injuries resulting in his death at 01:58.
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. – While a patient is admitted to an acute Trust ward for treatment for physical health treatment and is being held under section 5 (2) Mental Health Act for a Mental Health Act assessment due to concerns the patient presents a risk to themselves or others with a mental disorder, it permits the patient to be held for a maximum period of 72 hours. a. Patients admitted into the Accident & Emergency department detained under various sections of the Mental Health Act have a Responsible Clinician allocated. Patients who are not under section have access to the Mental Health Liaison Team. b. Patients admitted onto a ward at the acute Trust detained under various sections of the Mental Health Act have an allocated Responsible Clinician. As section 5 (2) is a holding power only, there is no

	Responsible Clinician allocated for a vulnerable patient being held pending assessment for consideration for detention under the Mental health Act. c. During the waiting period of up to 72 hours, Mental Health Liaison will not attend the acute ward or make assessment of the presenting risks of self-harm. d. The acute care healthcare professionals do not have specialist mental health training to conduct a mental health assessment and the consequential presenting harm. e. There was confusion at the acute Trust as to what regime was required to ensure that a patient awaiting Mental Health Act assessment could be put under 1:1 observation. The Trust policy was confusing and did not cover patients like Aaron Deeley. f. There is no joint protocol to cover the working between the two Trusts on this issue as the referral for Mental Health Act assessment goes outside of both organisations. There is a lacuna for patients awaiting Mental Health Act assessment and requiring simultaneous physical healthcare when a significant risk has been identified such that a patient may require detention for their own safety.
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 14 AUGUST 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: • Family of Aaron Deeley • 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	 **19 June 2024** **HM Area Coroner for Essex Sonia Hayes**