MISS N PERSAUD
HIS MAJESTY'S CORONER
EAST LONDON
Coroner's Court, 124 Queens Road Walthamstow, E17 8QP
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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: [REDACTED]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [REDACTED], Chief Executive Officer, Essex Partnership University NHS Foundation Trust [REDACTED]
1	**CORONER** I am Nadia Persaud, Area Coroner for the coroner area of East 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 12 April 2023 I commenced an investigation into the death of Danny Jay Anderson (aged 35). The investigation concluded at the end of the inquest on the 23 July 2024. The conclusion was that Danny Anderson died as a result of suicide, contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Danny Anderson suffered from chronic mental health difficulties, which first developed

around the age of 15. His past psychiatric history included serious incidents of self-harm and necessary admissions to hospital under the provisions of the Mental Health Act. In 2022, Danny required a six-week admission to hospital in February/March 2022, due to paranoid and delusional beliefs. In June 2022, Danny again required admission under the Mental Health Act for paranoid and delusional beliefs. He received care and assessment in hospital under Section 3 of the Mental Health Act. He received a number of possible diagnoses during the course of the admission. Evidence is accepted from an independent psychiatric expert, that Danny was likely to have been suffering from paranoid schizophrenia in 2022. This is based upon his presenting condition, requiring the admissions to hospital, and based upon his presentation throughout the six-month period in hospital - June to December 2022. Danny's condition was not correctly diagnosed before discharge from hospital. Danny was entitled to Section 117 after-care but no significant attention was given to his Section 117 after-care needs. Danny should have been assessed for supported accommodation. This was not done and supported accommodation was not sought for him. Danny was discharged to grossly inadequate hotel accommodation. Danny was discharged from hospital on the 14 December 2022. There was no comprehensive assessment of risk prior to discharge. There was no comprehensive safety plan put into place for him. Danny had stated his intention to stop his anti-psychotic medication before he was discharged from hospital, but no plan was put in place to address the clear risks of non-compliance with medication. The community mental health team did not communicate to the housing team, the importance of Danny being placed within the area of the community mental health team. Danny was placed out of area and was not seen face to face by his care co-ordinator before his discharge from the community team. Telephone contacts between Danny and his care co-ordinator raised significant concerns about Danny's mental health and living circumstances. Despite this, he was discharged from the community mental health team following telephone contact on the 18 January 2023. No communication was sent to Danny's GP to inform them of the discharge from mental health services. On the 30 March 2023, Danny was found hanging inside his room at [redacted]. Paramedics attended and pronounced his life extinct on scene. Police attended and deemed the circumstances as non-suspicious. Danny took his own life, whilst suffering from a mental illness, and whilst receiving absolutely no care from the mental health services. Danny's death was contributed to by cumulative failures, amounting to a gross failure, to provide mental health care to him

5 **CORONER'S CONCERNS**

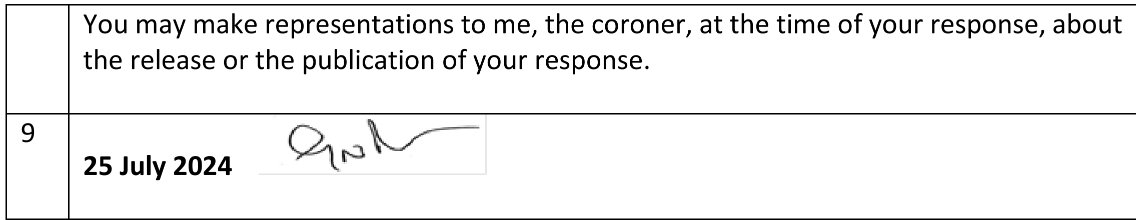
During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows:

There was no evidence of any adequate formulation of risk prior to Danny's discharge from hospital on the 14 December 2022 and no evidence of any adequate risk formulation prior to Danny's discharge from the community mental health team in January 2023.

The statement "Danny does not present with any suicidal ideation or self-harming behaviour" was copied and pasted multiple times throughout the risk assessment template on the 14 December 2022. There was no analysis or formulation of risk for

	Danny. From review of the records throughout the admission, I am concerned that there was an over-reliance upon Danny's answer to questions posed about suicidal ideation and intent. At the point of discharge, there was no evidence of information gathering around Danny's mental state, behaviour, psychiatric history, history of abuse, social situation – and evidence that this information was used to form a judgment about the likelihood or probability of an adverse or harmful outcome (in accordance with the Trust's risk policy). There was no evidence of any consideration of Danny's historical factors and experiences, more recent problems and existing strengths and resources (in accordance with the NICE guidelines 2022). Witnesses from consultant level to care co-ordinator level, were unable to describe a robust risk assessment process. I am concerned that staff do not fully understand how to assess and manage risk. There was no safety plan on discharge from hospital, or prior to discharge from the community team, to address the clear risks that Danny posed.
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 **19 September 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, to the family of Danny Jay Anderson, to the other interested persons to the inquest, to the Care Quality Commission, and the local Director of Public Health who may find it useful or of interest. 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	**25 July 2024**