Central and South East Kent Coroners' Service
Oakwood House
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Telephone: [redacted]
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Date: 15 July 2024
Case: [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

1. CORONER

I am Patricia Harding acting senior coroner for Central and South East Kent

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 21 March 2023 I commenced an investigation into the death of Phephisa Siphelele MABUZA. The investigation concluded at the end of an inquest held on 29th April 2024. The conclusion of the inquest was:

Narrative- Phephisa Mabusa was found at the base of [redacted] Dover on the morning of 14th March 2023 having died from injuries consistent with a fall from height. He was last known to be alive at 14.18 on the afternoon of 13th March 2023 when he was sighted walking alone toward the area where he was later found. He had travelled from South End on Sea to Dover by rail and had withdrawn cash on route. He had not taken olanzapine prescribed for psychosis for a number of months and was hearing voices in the days before his death but had not voiced any intention to take his own life. The evidence does not disclose how he fell or his intention at the time, but his death likely occurred on 13th March 2023

The medical cause of death was established following a post mortem to be from

1a Multiple Injuries

4. CIRCUMSTANCES OF THE DEATH

Phephisa Mabusa was diagnosed with psychotic disorder. He had been admitted to hospital as a result on a number of previous occasions, the last in July 2022 following which he was prescribed olanzapine in the community which he continued to take until the end of October 2022 when he moved out of the supported accommodation where he had been living and moved to Nottingham with his girlfriend.

Phephisa had been under the care of the Essex mental health team but was discharged from their service because of his move out of the county. His care co-ordinator advised him to register with a new general practitioner so his olanzapine prescription could continue and so that the mental health team could advise the new General practitioner of Phephisa's contact with the Essex Mental Health Services. Whilst he registered with a general practitioner, he did not request a prescription.

He returned to Essex on 4th November 2022 and although the supported accommodation where he had been staying was available to him, he decided together with his mother that he should get a job and get his own place rather than live in supported accommodation. He moved in with his mother. Phephisa registered with a general practitioner in the following days but did not ask for his olanzapine prescription to be restarted.

His mother did not become aware that he had not been taking his medication until February 2023 when she noticed that symptoms her son started to have when in the early stages of psychosis appeared to have returned. She called his general practitioner on 3rd March 2023 but was not available when the GP called back. She made further attempts to contact his general practitioner on 7th March 2023, but on this occasion did not receive a response and therefore on 10th March 2023 rang the 111 service where she spoke to a mental health nurse who conducted a telephone triage speaking to both Phephisa and his mother. The mental health nurse's conversation with Phephisa was very brief because Phephisa reported being tired.

The mental health nurse contacted the first response team to make a face to face appointment with Phephisa and also requested his general practitioner reconsider prescribing olanzapine again.

A prescription was sent electronically to the pharmacy, but the spine system disconnected and the prescription request would not go through. The prescription was therefore not available for sorry, the prescription was not therefore available for collection on 13th March 2024, when Phephisa's mother went to collect it. She did not see her son again and reported him missing when she returned from work the following day. Phephisa's death had been reported to Kent Police 10 minutes before he was reported missing to Essex Police.

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 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) Essex Partnership University NHS Foundation Trust Crisis Response Service follows the UK Mental Health Triage scale in classifying the urgency and service response requirements

of clinical presentations at the point of contact. The scale is embedded within the 111 Triage form utilised by clinicians in their clinical decision making following a triage. The Trust has departed from the national guidance for category D presentations such that the local guidance has been amended to reflect a 7 day response when the national guidance states 72 hours

(2) Essex Partnership University NHS Foundation Trust's existing standard operational policy document for the Crisis Response Service incorrectly states triage codes D and E on the appendix as 'within 24 hours- same day response@ and do not reflect the scale on the 111 Triage form or the national guidance.

I delayed issuing this report so that the Trust could inform me of the current position and whether any remedial action had been taken.

A memo has been sent to all staff to notify them that the operational policy has been wrongly coded but a decision had not yet been taken as to whether and how the Trust intended to move forward in respect of the departure from the national guidance

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you Essex Partnership University NHS Foundation Trust 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 9th 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 and to the following Interested Persons the legal representatives of the family I have also sent it to the senior coroner for Essex who may find it useful or of interest.

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.

15 July 2024

Signature 

Patricia Harding Senior Coroner for Central and South East Kent