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 of North East London 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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 4 January 2022 an investigation was commenced into the death of James Warren Agius aged 42. The investigation concluded at the end of the inquest on 4 October 2024. The conclusion of the inquest was Suicide with a medical cause of death of1a Suspension by Ligature.
4	**CIRCUMSTANCES OF THE DEATH** James Agius was found deceased at home on 17 December 2022 on a welfare check, [redacted]. Mr Agius had a mental health disorder and severe complex trauma and was undergoing trauma therapy. There was a history of previous suicide attempts and self-harming and substance misuse for which he sought assistance from the mental health team. Mr Agius appeared to read a phone message on the morning of 17 December 2022 but had not responded. Mr Agius suspended himself on 17 December 2022 and intended the outcome to be fatal.
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. – 1. The medical record documentation for Mr Agius had significant omissions that included an incomplete risk assessment in February 2022 for Mr Agius following his transfer following crisis intervention with the Home Treat Team to avoid an admission to hospital when Mr Agius attempted to take his own life.

	2. The evidence of assessments of Mr Agius's mental state provided to the inquest indicated a difference of opinion as to whether Mr Agius was displaying hypermanic symptoms on 12 and 13 February 2022. 3. Evidence was heard that there is new national training for assessing risk for patients with mental health concerns but there was no evidence that the Trust has implemented this training.
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 2 DECEMBER 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 Mr Agius. I have also sent it to the Care Quality Commission 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. She may send a copy of this report to any person who she 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	**7 OCTOBER 2024** S. M. Hayes **HM Area Coroner for Essex**