REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] CEO of Essex Partnership NHS Foundation Trust**
1	**CORONER** I am Sean Horstead, HM 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 20th June 2022 I commenced an investigation into the death of Jamie Harding, aged 31 years'. The investigation concluded at the end of a 5-day inquest on 12h April 2024. The medical cause of death was confirmed as: I (a) Multiple severe Injuries I (b) Fall from Height II Psychotic Disorder The Deceased had been under the care of the Essex Partnership NHS Foundation Trust (EPUT) Essex Support and Treatment for Early Psychosis (ESTEP) between 2017 and 2020 and he had been prescribed anti-psychotic medication and allocated a Care Coordinator. The inquest heard evidence that Jamie had engaged relatively well with his care plan and was reporting improvements in his symptoms. However, he began to disengage with services in 2019, which appears to have coincided with the replacement of his Care Coordinator. He was discharged from EPUT services in November 2020. Jamie's GP continued to be prescribed anti-psychotic medication. Two separate and urgent GP referrals were made to EPUT in November 2021 requesting an urgent review of Jamie, as he was hearing voices, experiencing paranoia, and reporting that his medication was not working. His mother also contacted EPUT directly. On 18 January 2022, Jamie was assessed by EPUT's First Response Team (FRT) via telephone. Jamie described his symptoms, reported that he was binge drinking, and requested different medication. A plan was put in please

	for Jamie to self-refer to a drug an alcohol service, and for his case to be discussed in a Multi-Disciplinary Team meeting ('MDT'). The evidence disclosed that in the six months that followed this assessment there were a series of significant and repeated failures on the part of EPUT employees, together with inadequacies in the systems of operation of EPUT's First Response Team, in the care, management and treatment provided to Jamie. My *Narrative Conclusion* recorded that the Deceased took his own life whilst the balance of his mind was disturbed and, further, recorded that a number of significant and repeated failures contributed to the avoidable death. The cumulative effect of these failures amounted to a gross failure to provide Jamie with basic medical care at a time that his condition clearly required it and, in this respect, neglect directly contributed to Jamie's death.
4	**CIRCUMSTANCES OF THE DEATH** On the 3rd of June 2022 Jamie, accompanied by his mother, presented at Basildon Hospital A&E Department in crisis and seeking help for his further deteriorating mental health on a background of some three days lack of sleep and ineffective anti-psychotic medication failing to ameliorate the on-going and extreme paranoia and psychotic symptoms he was experiencing. In the context of on-going suicidal ideation and a subjective mood score recorded as 0/10, he was appropriately referred to the Mental Health Liaison Team (MHLT) for assessment by the A&E doctor. The assessment subsequently undertaken by the MHLT practitioner was inadequate and failed to appropriately act upon relevant information available to him including (but not limited to) information provided by Jamie's mother regarding her son's on-going suicidal ideation and her (and Jamie's) expressed request for him to be admitted to hospital as a voluntary in-patient as she, and Jamie, did not feel able to keep him safe. Although the MHLT clinician gave evidence that he had concluded *that Jamie required and would benefit from a period of admission as an in-patient*, no such admission was sought or planned. Instead, Jamie was discharged home with a plan for him to be seen the following day by the Home Treatment Team. He was provided with a (daily) tablet of Zopiclone for the next seven days. Within hours Jamie had taken his own life having fallen a significant height from a window at his home address. The failure by the MHLT practitioner to initiate the process for Jamie's admission to an in-patient bed constituted a clear missed opportunity to ensure appropriate and likely effective steps were taken to mitigate his high risk of acting upon his clear suicidal ideation.

	The cumulative effect of the series of serious failures in the six months preceding the events of the 3rd of June amounted to a gross failure to provide Jamie with basic medical care at a time that his condition clearly required it. In this respect, neglect directly and more than minimally contributed to Jamie's death. The failures identified included: (a) a serious failure to adequately follow up a plan identified in an assessment undertaken on the 18th January 2022 by a First Response Team (FRT) Assessor and a Trainee Doctor. The lack of any adequate follow up led directly to a failure to conduct a full Multi-Disciplinary Team Meeting (MDT) in respect of Jamie's complex, on-going presentation involving increasing paranoia and psychotic-like symptomology in conjunction with on-going alcohol misuse; (b) a failure to undertake an urgent medication review over the same six-month period despite repeated requests for the same from GPs, Jamie himself and his mother; (c) the failure to hold a full MDT was a significant missed opportunity to allocate a Care Coordinator to Jamie and a missed opportunity to involve the Dual Diagnosis Service in Jamie's care; (d) absent a full MDT and the allocation of a Care Coordinator, there was a serious missed opportunity to develop an appropriate Care Plan for Jamie and undertake regular, up-dated risk assessments regarding self-harm and suicide; (e) On the 20th May an EPUT Consultant Psychiatrist declined to undertake a review of Jamie's medication, or any further form of review as requested by Jamie's GP: this too was a serious missed opportunity.
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. – (a) The accepted absence of effective formal, compulsory training for clinicians regarding the Dual Diagnosis (DD) pathway and what it does and does not provide, how to access it and the potential benefits of it. The evidence confirmed that practitioners outside of the DD

	workers/pathway were unaware how they could contact them, including directly. (b) In addition to weak record keeping and poor communication with patients and their families, the evidence revealed the lack of a robust and reliable system to ensure that the FRT deals with its caseload efficiently and effectively and particularly how it flags and then follows up referrals to and queries from other services/clinicians contributing, in turn and on the facts of this case, to the significant failure to hold an MDT. The FRT did not follow up (as it was accepted it should have) the referral (via a self-referral) to Open Road or the referrals for a medication review. Had there been such follow up, EPUT evidence confirmed that there would likely have been a discussion of Jamie's case at a full MDT with the likely allocation of a Care Coordinator, the likely involvement of the Dual Diagnosis pathway and the likely use of the RAG rating system to ensure on-going risk assessment. In my opinion these features give rise to a clear risk of future deaths and must be addressed.
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 23rd 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: The family of the deceased, via their instructed lawyers at Leigh Day Solicitors. 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	**29.10.2024**	**HM Area Coroner for Essex Sean Horstead**