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 of Essex Partnership University NHS Trust** **2. Chief Executive OF Mid & South Essex NHS 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.
3	**INVESTIGATION and INQUEST** On 20 June 2023 I commenced an investigation into the death of DAVID WAYNE BENNETT, AGE 42. The investigation concluded at the end of the inquest on 29 January 2025. The conclusion of the inquest was 1a Hanging. Suicide: Mr Bennett did not receive an assessment of his mental health deterioration on 1 June or 6 June 2023 when he sought assistance and medication for his mental health deterioration.
4	**CIRCUMSTANCES OF THE DEATH** David Bennett died due to hanging on 13 June 2023 at [redacted] where he was found suspended by a ligature [redacted] with ingestion of cocaine and alcohol. Mr Bennett had a history of drug induced psychosis that had been treated in the past with antipsychotic medication. Family raised concerns with the GP who advised to call mental health crisis services about Mr Bennett's safety on 25 May 2023 due to a deterioration in his mental health. The crisis team advised that a person would need to be with Mr Bennett for assessment, there was no follow-up. Mr Bennett's request for medication for psychosis on 1 June 2023 to the primary care mental health services was not actioned or escalated and at the time there was a current prescription of antipsychotic medication on his GP records. Mr Bennett

	attended the acute Trust emergency department on 6 June and informed staff that the Mental Health Urgent Care Centre was closed. Mr Bennett requested medication for psychosis and lack of sleep. Mr Bennett was not assessed or reviewed by mental health services at hospital and was signposted back to primary care and substance misuse services. Mr Bennett was sent a copy of his GP summary and said he was going to try to access a 'treatment clinic'.
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) Evidence was heard that the mental health crisis staff do not appear to have appropriate access to the primary care mental health System One records and there is a risk that vital information is not being shared. (2) The Operational Policy Mental Health Urgent Care Department pathways Appendices are not clear and do not appear to accord with the implementation. (3) Recent contact with the primary care mental health records did not appear to be accurately recorded in the System One Records with suicidal ideation not recorded. (4) Mr Bennett requested a GP appointment; a telephone appointment was made with the primary care mental health nurse. The primary care mental health nurse on 1st June did not escalate Mr Bennett to the GP or Community Psychiatrist when Mr Bennett was adamant he wanted to see a doctor and required an urgent medication review for his deteriorating mental health. (5) Mr Bennett had an open prescription for antipsychotic medication on his GP record that was not being requested and the primary care mental health nurse did not ask about this and the nurse did not inform the GP or seek any advice from her line manager who was a nurse prescriber.

	(6) Mr Bennett attended the acute hospital Trust for his deteriorating mental health. The acute Trust hospital nurse sought advice from the mental health liaison nurse. The acute Trust nurse did not have access to the mental health or GP records and not all available information was shared with the acute Trust nurse. (7) The mental health liaison nurse asked the acute Trust nurse to undertake the risk assessment for Mr Bennett's mental health. This is the role and purpose of mental health liaison.
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 April 2025. 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 I have also sent it to Care Quality Commission who may find it useful or of interest. 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 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	 **17 February 2025**

	HM Area Coroner for Essex Sonia Hayes