REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Chief Executive Officer of Essex Partnership University NHS Foundation Trust, [redacted], *Essex Partnership University NHS Foundation Trust, The Lodge, Lodge Approach, Runwell, Wickford, SS11 7XX***
1	**CORONER** I am Sean Horstead, 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 31st October 2023 I commenced an investigation into the death of DARREN NEIL TURNER, aged 37 years. The investigation concluded at the end of a 9-day article 2 non-jury inquest on the 28th February 2025. Darren Neil Turner was found deceased on 20th October 2023 in a wooded area in Essex. The evidence disclosed that the deceased likely took his own life on the morning of the 18th October 2023. The medical cause of death was confirmed as '1a Hanging'. In a narrative conclusion I recorded that the deceased took his own life in the context of multiple failures in the care, management and treatment provided to him by the Essex Partnership NHS Foundation Trust (EPUT) and that those serious failings amounted to neglect.
4	**CIRCUMSTANCES OF THE DEATH:** On the 23rd September 2023 after concerns were raised that Darren, at his home address, was threatening to take his own life having consumed a potential overdose of medication whilst intoxicated with alcohol, the East of England Ambulance Service (EEAST) and Essex Police attended and attempted to facilitate a medical assessment of Darren. He would not consent to such an assessment and EEAST staff, deeming him to have mental capacity, and Essex Police, left him at the property. The following day, whilst apparently experiencing a serious mental health crisis, Darren caused extensive damage,

	and set fire, to the home he had shared with his former long-term partner, in what was an attempt to end his life. He was arrested and detained under Section 136 of the Mental Health Act (MHA) 1983 and, following an assessment, was subsequently detained under Section 2 of the MHA and admitted as an in-patient to Gosfield Ward, an Acute Psychiatric Unit at the Lakes Mental Health Unit, Colchester, Essex under the care of EPUT on 26th September. Although Darren had no significant previous recorded history of mental health problems, he did have a history of alcohol misuse which had worsened over the two to three years preceding his death whilst working from home as a consequence of the Covid pandemic. A trigger for events in September 2023 appears to have been the ending of his long-term relationship, itself a consequence of Darren's drinking. The evidence disclosed multiple significant failings in the care, management and treatment of the deceased up to and including the rescinding of his Section 2 MHA detention and subsequent discharge from Gosfield Ward at around 2 pm on the 17th October 2023. These failings, individually and cumulatively, more than minimally contributed to his self-inflicted death by hanging within some 18 hours or so of the rescinding of the Section 2 detention and Darren's discharge. Taken together, the causative failures identified during the course of the inquest constituted gross failures and, accordingly, led to a finding that neglect contributed to Darren's avoidable death.
5	**CORONER'S CONCERNS:** A significant number of the serious causative failings identified in this case have previously informed PFDRs issued to EPUT. In June 2024 a 'Thematic Analysis' Review Document prepared by EPUT's 'Lessons Team' identified *'Triangulated Themes'* from a review of nine PFDRs issued in the Essex Coronial jurisdiction between June 2021 and January 2024. The Review acknowledged six 'Triangulated Themes' in respect of which failures causative of deaths had been, and continued to be, identified, namely: *Communication; Training & Supervision; Record Keeping; Discharge Planning; Care Planning; Risk Assessment*. (Further PFDRs issued to EPUT in October 2024 and February 2025 raised similar, related concerns). During Darren's inquest continuing failings under precisely the themes identified emerged once more as having informed the serious causative features contributing to Darren's death. In my opinion, the actions taken by EPUT to date to address the acknowledged failings reflected under the themes referred to have been, and remain, inadequate and incomplete; Accordingly, during the inquest the evidence revealed matters giving rise to concern and, 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) Failures in Care Planning: specifically, a failure to appropriately up-date and document matters relating to Darren's Care Plan consistent with Trust policy. The last up-date to his Care Plan was 12 days prior to discharge. (b) Failures in Documentation: in a number of acknowledged respects the electronic records were inadequate - and inconsistent with EPUT policy - with evidence of the *'cutting and pasting'* of entries including Darren's initial 72-hour care plan containing details of another patient entirely. (c) Failures in Risk Assessments: specifically, failures to appropriately up-date and document matters relating to Darren's risk assessment consistent with Trust policy. Relevant passive and active risk factors were not formally reflected in his documented risk assessments. Evidence from his Responsible Consultant Psychiatrist and the discharging Psychiatrist confirmed that, had they been aware of a disclosure made by Darren to his key worker/nurse prior to discharge, the Section 2 detention *would not* have been rescinded, he *would not* have been discharged on the 17th October and, accordingly, it is likely that he would not have taken his own life the following day. (d) Failure to allocate a Care Coordinator as required under the Care Programme Approach (CPA) and as mandated by EPUT policy. This failure (resulting from significant human error not detected by an insufficiently robust system and not therefore corrected prior to the death - and in respect of which no DATIX was ever raised) was a feature that contributed to the serious failure in discharge planning in this case. (e) Failures in Communication including a failure to appropriately liaise with the deceased's Family and, specifically, Darren's mother to establish the suitability and safety of a discharge to her address not least in the context of Darren's disclosure that discharge to his mother's home might *"make him feel worse"* at a point in time that he later acknowledged *"would be overwhelming"* for him. (f) Failures in Discharge Planning and Execution: specifically, in addition to the features above, a failure to actively reconsider the safety of the discharge on the afternoon of the 17th October in light of the disclosure from Darren's mother that she would not, as had been previously indicated, be able to either collect Darren from the Ward or be at her home when he was discharged. There was no evidence of how, in fact, Darren even left the Unit. It is likely that the chaotic and unsupported nature of Darren's discharge from Gosfield Ward, also in breach of Trust policy, more than minimally contributed to his death some 18 hours after discharge.
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 12th May 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: [redacted], sister of the deceased; [redacted], former partner of the deceased; Essex Police; East of England Ambulance Service. 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	 **HM Area Coroner for Essex Sean Horstead** **17.03.2025**