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**
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 29 March 2023, I commenced an investigation into the death of Julie Sheila BEASLEY, AGE 66. The investigation concluded at the end of the inquest on 24 March 2025. The conclusion of the inquest was 1a Multiple Drug Misuse. Mrs Beasley's deteriorating mental health that included recent overdose, suicidal thoughts and plans remained untreated. Mrs Beasley made multiple contacts requesting a review and did not have the required mental health risk assessments or a medication review and this contributed to her death by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Julie Sheila Beasley was found deceased at home on 16 March 2023 and died of Multiple Drug Misuse due a fatal amount of Morphine with concomitant use of her prescribed medications. Mrs Beasley had received treatment for her mental health in the past and last had contact with mental health services in December 2020. Mrs Beasley made 8 contacts with the mental health services for her deteriorating mental health between 23 January 2023 and 21 February 2023 with escalating risks and requesting a review of her mental health medication as it was not working. Mrs Beasley did not receive a V4 assessment or a medication review. Mrs Beasley responded promptly to a request from mental health services for an urgent assessment due to her level of risk, this then did not take place. Mrs Beasley stated to mental health crisis

	staff that she did not want to die but this was no way to live and wanted a medication review as her medication was not working. Mrs Beasley was taking additional medication to attempt to cope with her deteriorating mental health that remained untreated.
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) Mrs Beasley was seen at home following a call to the mental health crisis team and required a full V4 mental health assessment that did not take place and instead an SBAR review was completed, and the nurse did not scrutinise the medications and medication changes that had been previously made and made errors about the doses. Mrs Beasley was informed she was discharged back to her GP, but no actions were sent by the mental health Trust to the GP. (2) Following this Mrs Beasley contacted crisis mental health explaining that she had vital information that she had not shared following a visit by a psychiatric nurse at her home. Mrs Beasley was not asked what the information was. Mrs Beasley contacted the crisis team again a few days later repeating that she had not shared information and again was not asked what the information was and was not given an appointment. Mrs Beasley's telephone contacts were noted in her medical record with no details recorded as to what the additional information Mrs Beasley wanted to share. Mrs Beasley did not receive the appropriate psychiatric assessment following her contact with the crisis team. (3) Mrs Beasley was conveyed to hospital having taken an overdose of medication and was reviewed by the Trust mental health liaison team. Review of the mental health Trust medical records would have shown that Mrs Beasley had an SBAR review rather than a V4 mental health assessment. This should have alerted staff to the fact that an urgent assessment was required when Mrs Beasley attended mental health liaison following an overdose of her medication. This did not happen. (4) Mrs Beasley had been requesting an urgent appoint and responded immediately to a letter from the Trust informing her she needed an urgent psychiatric appointment. When Mrs Beasley contacted the crisis team, she was again informed incorrectly that she had recently had a V4 psychiatric assessment and did not require an urgent appointment.

	The crisis team were not communicating effectively either with Mrs Beasley, her GP or internally within their own team. (5) Multiple experienced members of the mental health teams had contact with Mrs Beasley between January and March and did not make detailed entries into the medical or ask questions of Mrs Beasley about what additional information she had to provide about her risks of harm and suicidal ideation, review of her medication given her deteriorating mental health and calls to the crisis team disclosing increasing suicidal thoughts and ideation accompanied by acts and plans. There was a lack of professional curiosity and poor record keeping and rationale for decision-making.
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 23 July 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 • General Practitioner 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	S. M. Hayes **28 May 2025**

	HM Area Coroner for Essex Sonia Hayes