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 1 August 2025 an investigation was commenced into the death of Nicholas Alan GRAY, AGE 63. The investigation concluded at the end of the inquest on 5 June 2025. The conclusion of the inquest was 1a [redacted] Toxicity Suicide: Mr Gray took an overdose of [redacted] with the intention to end his life. Mr Gray was discharged home in the absence of a psychiatric review or recommended mental health risk assessment.
4	**CIRCUMSTANCES OF THE DEATH** Nicholas Alan Gray died at home on 24 July 2023 of [redacted] Toxicity. Mr Gray had a history of suicidal thoughts and anxiety with low mood and depression contributed to by an exacerbation of pain of a chronic spinal condition with recent surgery. Mr Gray was receiving pain management and commenced an on antidepressant on 12 June 2023. Mr Gray made attempts to stab himself on 18 June 2023 with the intention to end his life and was seen by paramedics and the primary mental health team. Whilst en-route to hospital Mr Gray wished to go home, and an ECG raised concerns about an underlying cardiac issue. Further advice from primary mental health was that Mr Gray had capacity and therefore was taken home. No plan was put in place for assessment of Mr Gray's mental health or risk to himself. On 22 June 2023 Mr Gray informed district nurses that he was going to end his life, this was escalated to his GP who contacted the mental health crisis team. Mr

	Gray was conveyed to hospital. On 23 June district nurses updated the acute trust nurse that Mr Gray had knives in his bed at home, had attempted to hang himself, were concerned about Mr Gray's safety at home and asked that he have a mental health assessment prior to discharge. Mr Gray was reviewed by and closed to mental health services on 24 June with no further action. Mr Gray was not referred to the psychiatrist during his 3-week admission and not reviewed by mental health services prior to discharge. Mr Gray received treatment for his physical healthcare and alcohol withdrawal and discharged on 17 July 2023.
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) The Trust PSIRF Decision Monitoring Tool completed after Mr Gray died contained inaccurate information, the dates of EPUT contact and the substance of the interactions were inaccurate: a. Self-harm was noted as "none known or recorded" b. There was no record of the mental health liaison nurse review on 24 June 2023 and the discharge of Mr Gray from EPUT. The information used to inform a potential investigation requirement contained significant omissions and was not consistent with the information known to the Trust.
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 31 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	 **5 June 2025** **HM Area Coroner for Essex Sonia Hayes**