REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** ***The National Medical Director, NHS England*:** [redacted] ***and*** ***Secretary of State at the Department for Health and Social Care:***
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 23rd June 2023 I commenced an investigation into the death of Jack Mathew Peatling, aged 20 years. The investigation concluded at the end of the article 2 (non-jury) inquest on the 10th October 2025. The Conclusion of the inquest was a Short Form Conclusion of Suicide in conjunction with an expanded Narrative Conclusion expressed (in summary) in the following terms: Jack Peatling's death was directly contributed to by the non-availability of an in-patient bed in an EPUT Mental Health Assessment Unit. His very high level of risk of suicide had been determined by a formal Mental Health Act assessment to require an immediate period of assessment and treatment as in-patient with a recognition, in terms, that his risk of suicide was such that he could not be kept safe in the community. Jack spent six days at home awaiting a bed before taking his own life by the fatal deployment of a ligature.
4	**CIRCUMSTANCES OF THE DEATH**

	On a background of diagnoses of anxiety and depression and historical attempts at suicide and repeated self-harm, Jack made two further serious attempts to take his own life, on the 29th May 2023. When his mother intervened and frustrated these suicide attempts, he inflicted a grave wound to his left arm [redacted] Following a formal Mental Health Act (MHA) assessment at Basildon Hospital the following day, Jack's (informal) admission to a Mental Health Assessment Unit (MHAU) was confirmed as urgent and necessary for appropriate assessment, management and treatment of his anxiety and depression and his impulsive suicide attempts. With the agreement of Jack and his mother, the assessment determined that in the context of his on-going very high level of risk of suicide, with high levels of impulsivity, Jack could not be safely managed in the community. Over the next 6 days the Essex Partnership University NHS Foundation Trust (EPUT) were unable to identify the required in-patient bed anywhere in Essex. Evidence confirmed that demand for such beds outstripped supply and that this had been and remained a chronic issue, locally and nationally. Attempts were made to manage Jack's risk of suicide in the community with a single visit from a Home Treatment Team (HTT) Psychiatrist on the 31st May and then subsequent short daily visits to Jack at his family home by an HTT Community Psychiatric Nurse. *It was acknowledged by the professionals involved in the MHA assessment itself, by the HTT clinicians and psychiatric nurses subsequently involved, as well as by Jack himself and his mother, that his risk of suicide could not be safely managed in the community.* Accordingly, Jack's death by suicide on June 5th 2023 was directly contributed to by the non-availability, over several days, of a bed in an EPUT MHAU in Essex.
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) A highly vulnerable 20-year-old man, with a history of anxiety, depression and impulsive previous suicide attempts made two further serious attempts to take his own life and inflicted an extensive wound to his arm [redacted] after those suicide attempts were frustrated by his

	mother. The subsequent formal MHA assessment determined Jack to be such a high risk of suicide that an immediate period of assessment and treatment as a (voluntary) in-patient on an MHAU was required *as his high risk of suicide could not be safely managed in the community*. (b) No such bed was available over the six days between the MHA assessment and Jack's suicide with still no indication, at the time of his death, as to if or when a bed would be available. By default, and notwithstanding point (a) above, the HTT, absent an in-patient bed, became responsible for his care in the community. (c) In his evidence, it was further expressly recognised by the HTT psychiatrist who saw Jack on the 31st May that his *"very, very high risk*" of suicide at that time could not be managed safely in the community by the HTT and, further, that Jack was *"untreatable"* in the community. (d) Nonetheless, and notwithstanding the unanimous clinical view, the non-availability of an EPUT MHAU in-patient bed meant that *the HTT were required to attempt to mitigate this unmanageable level of risk in the community*, *something that the HTT was, as had been anticipated, unable to do*. (e) The evidence confirmed that a lack of available in-patient beds for high-risk mental health patients who, as was acknowledged at the time, cannot be managed safely in the community, is a chronic and on-going situation in Essex and, the inquest was told, nationally. (f) Jack took his own life by deploying a ligature [redacted] on the sixth day awaiting the necessary, required in-patient bed. Had an in-patient bed been made available, he would probably not have died. Jack's death was avoidable. (g) Absent the provision of available mental health in-patient beds for very high-risk patients that formal Mental Health Act assessments have clinically determined cannot be managed safely in the community, then further avoidable deaths by suicide amongst this cohort of vulnerable patients appears inevitable.
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 5th December 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: *The Family of the deceased.* *Essex Partnership University NHS Foundation Trust.* *Essex County Council.* *Mid and South Essex NHS Foundation Trust.* 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. 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	**13.10.2025 HM Area Coroner for Essex Sean Horstead**