REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: Chief Executive Officer - Mid & South Essex NHS Foundation Trust Chief Executive Officer - Essex Partnership University NHS Trust
1	**CORONER** Dr. Jeane Rosa Mellani, HM Assistant 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 19 September 2024 I commenced an investigation into the death of Mr Warren James Green. The investigation concluded at the end of the Inquest on 28 November 2025 and the conclusion was that Mr Green died from 1(a) Traumatic Subdural Haemorrhage and 1b) Skull Fracture, sustained following Mr Green jumping through the gap of a four-storey stairwell whilst on the acute ward. The conclusion was a narrative focused on both the delay in securing a psychiatric bed to move Mr Green to a mental health unit upon becoming fit for discharge from the acute ward and failings in safeguarding Mr Green from the high risk of self-harm, whilst he remained on the acute ward. Both of which probably more than minimally contributed to Mr Green's sad death.
4	**CIRCUMSTANCES OF THE DEATH** Mr Green was suffering from mental health issues and following a serious attempt on his life on 2 August 2024, Mr Green was admitted to hospital under the care of the Mid and South Essex NHS Foundation Trust. He became fit for discharge from the acute ward on 10 August 2024. Although Mr Green was assessed as being liable for detention under section 2 of the Mental Health Act 1983, this detention was never formalised due to the delay in sourcing a psychiatric bed. Mr Green's discharge to a psychiatric bed was delayed and he remained an impatient in the acute hospital. On 20 August 2024, the Acute hospital failed to put in place the arm's length supervision necessary to keep Mr Green safe and manage the high risk of self harm, due to funding authorisation not been provided. On the same day, whist unsupervised, Mr Green was able to access an open fire escape stairwell placed at the far end of the T- shaped acute Ward located in a low traffic and not overlooked area of the Ward without being seen by any staff and took his own life by jumping through the gap of a four-storey stairwell. Mr Green sustained a skull fracture which led to his death from traumatic subdural haemorrhage.

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 could 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 evidence identified a risk of patients at high risk of self-harm being able to leave the acute ward without appropriate risk assessment (2) The evidence identified a risk of patients at high risk of self-harm being able to leave the acute ward without the knowledge of the hospital staff The above shows a lacuna in terms of patients' safety and safeguarding. (3) The evidence showed that the Mental Health Liaison Service relies on nurses to conduct initial assessments and follow up reviews of patients suffering with mental health issues and the mechanism by which escalation to a Consultants Psychiatric is decided and the factors to be taken into account for escalation are not at all clear. This leads to lack of Consultant's oversight for these vulnerable patients.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe yourselves and your organisations 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 10 March 2026. 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 Mr Green • Mid and South Essex Integrated Care Board • Care Quality Commission I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.

9	**12.01.2025**	**SIGNED BY CORONER – Jeane Rosa Mellani**