REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] **Secretary of State for Health and Social Care,** *Department of Health & Social Care, Ministerial Correspondence and Public Enquiries Unit, 39 Victoria Street, London, SW1H 0EU* 2. **Chief Executive Officer of NHS England,** [redacted] *Skipton House, London SE1 8UG* 3. **Chief Executive Officer of Essex Partnership NHS Trust,** [redacted], *Essex Partnership University NHS Foundation Trust, The Lodge, Lodge Approach, Runwell, Wickford, SS11 7XX* 4. [redacted] **Chief Executive of Health Education England** [redacted]
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 17th June 2021 I commenced an investigation into the death of John David Moore, aged 39 years'. The investigation concluded at the end of the inquest on the 4th February 2022. The conclusion of the inquest was one of suicide, with a medical cause of death of '1a Fatal pressure on neck'.
4	**CIRCUMSTANCES OF THE DEATH** Mr Moore had a history of homelessness and mental health issues with diagnoses of ADHD, bi-polar disorder and illicit substance misuse. In the two years or so preceding his death he had been hospitalised on a number of occasions following suicide and/or serious self-harm incidents. His last period as a voluntary mental health in-patient was between 7th and 18th March 2020 having been admitted to the Peter Bruff Mental Health Assessment Unit, King's Wood Centre, Colchester following a suicide attempt. At the time of his admission, it was considered that his risk was such that it was not safe to manage that risk in the community. At the time of his admission, he was street homeless; at the time of his discharge, he remained homeless and was discharged back to the streets. Mr Moore was involved with the criminal justice system and the nature of his offending history impacted on the range of options available regarding housing or accommodation.

Following his discharge, he was under the care of the Essex Partnership University NHS Trust (EPUT's) (then) Specialist Mental Health Team. In mid-April 2020, he was allocated a Care Coordinator. Some two weeks after discharge from Peter Bruff he was hospitalised for five days following an overdose of [redacted]l. Over the next three months, and in the context of the first Covid-19 pandemic lockdown, his contact with his Care Coordinator was limited to two telephone calls with no face-to-face contact at all. On July 7th 2020 he was discharged from the SMHT back to the care of his GP. However, his GP's last documented contact with Mr Moore was at the end of March 2020.

At the time of his death on the 10th June 2021, when he took his own life by attaching a ligature [redacted], Mr Moore was again homeless; he had received no intervention from primary or secondary care since the contact in 2020 outlined above. Despite the very best efforts of his mother, he had also disengaged from family and friends. At the time of his death, as at the time of his last mental health in-patient admission 15 months earlier, he retained a number of markers for increased risk of suicide, namely: male, single, homeless, illicit substance misuse.

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CORONER'S CONCERNS

During 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.

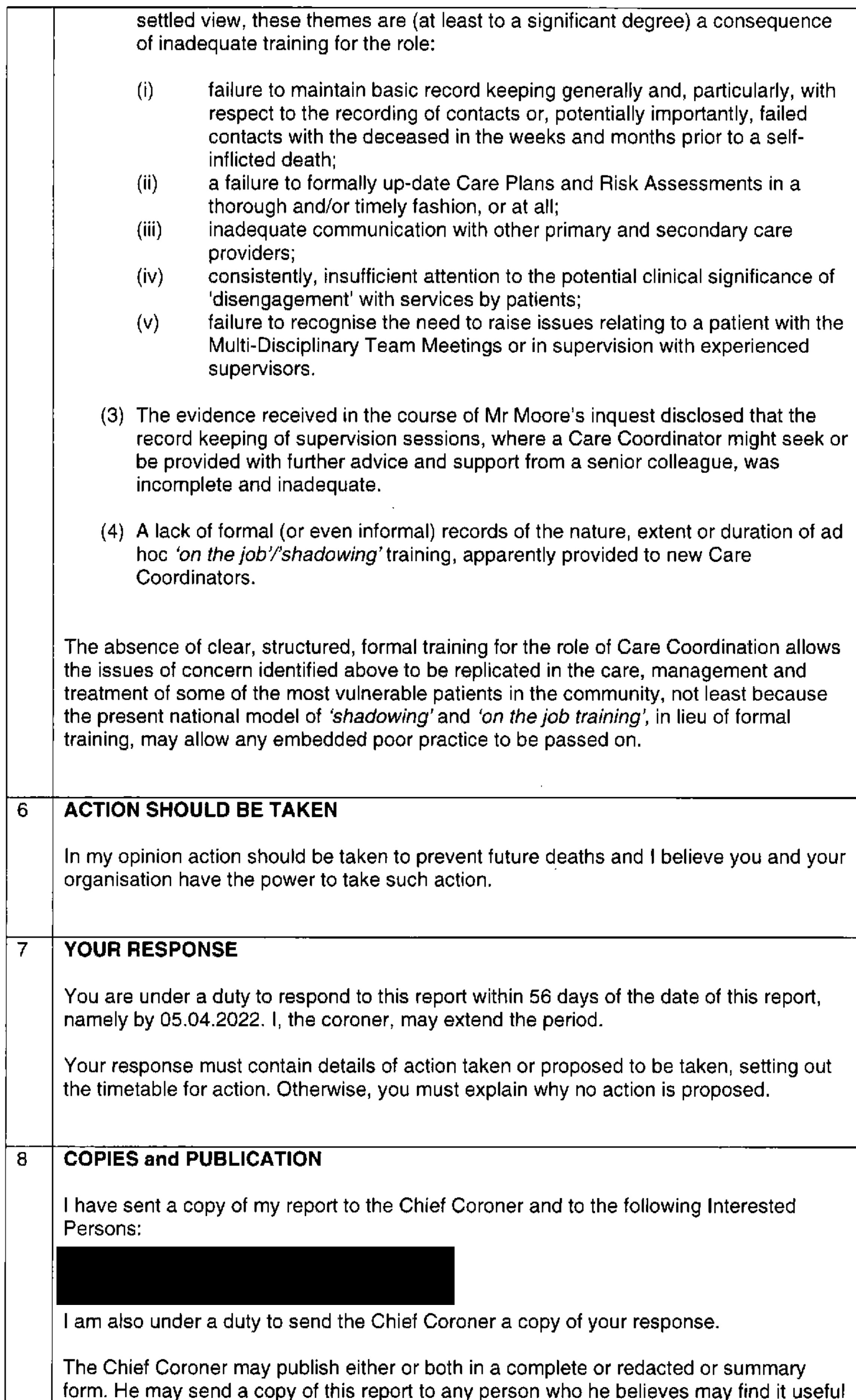
The **MATTERS OF CONCERN** are as follows. –

The evidence in this case echoed that received in a number of recent inquests held in this jurisdiction concerning the deaths of individuals with a history of involvement with EPUT mental health services. Whilst in the specific circumstances of this case, and the context of the Covid-19 pandemic, the disengagement of the deceased from primary and secondary health care providers and the performance of his Care Coordinator could not be concluded to have probably caused or contributed to Mr Moore's death more than minimally, (given the length of time between last contact and the suicide some eleven months later), nonetheless common themes were identified in evidence which replicated shortcomings and failures in those other cases, the continuation of which give rise, in my view, to the risk of future deaths.

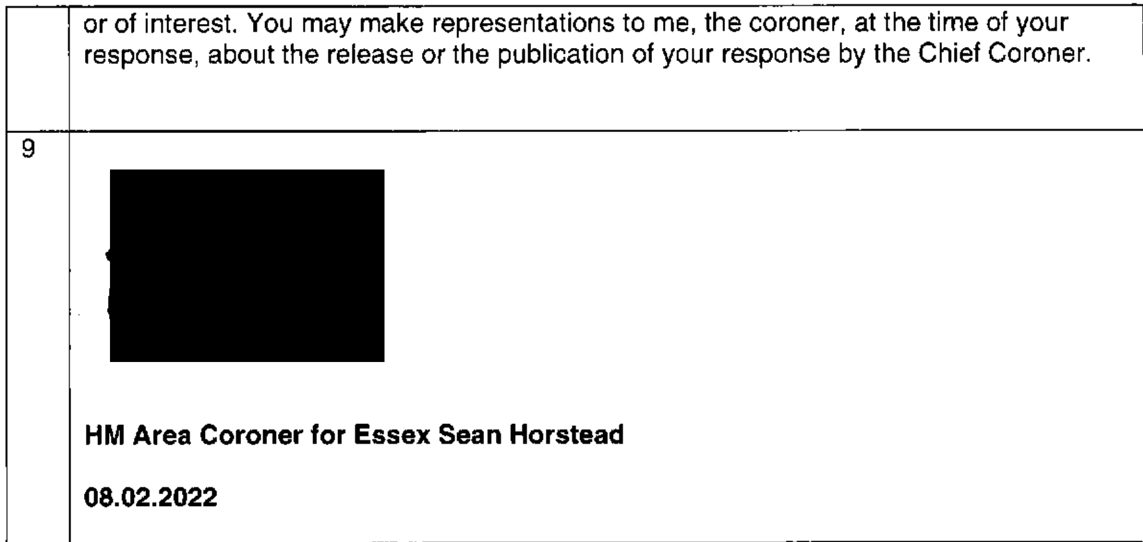
Specifically:

(1) EPUT Care Coordinators receive inadequate training for the role. Care Coordinators carry significant responsibilities to coordinate the care provided to an often extremely vulnerable cohort of patients. This responsibility was significantly heightened in the context of the Covid-19 pandemic, and the accompanying periods of 'lockdown', when vulnerable and often isolated sufferers of mental health illness and disorders, including those with substance misuse issues, became increasingly isolated and thus increasingly vulnerable. Notwithstanding the imposition of this additional responsibility, the evidence in this and similar coronial investigations has established that Care Coordinators receive *no formal training for the role* and, at best, are introduced to it via the *'shadowing'* of colleagues *'on the job'*. At inquest evidence was provided by an experienced (Band 8a) EPUT Clinical Manager that the lack of formal training for the pivotal role of Care Coordinator within EPUT is one that reflects the same practice in NHS Trusts across the country.

(2) The evidence in this case, and in other recent inquests heard by me and fellow coroners in this jurisdiction, establishes the following common themes in respect to the inadequate performance of several EPUT Care Coordinators. In my



	settled view, these themes are (at least to a significant degree) a consequence of inadequate training for the role: (i) failure to maintain basic record keeping generally and, particularly, with respect to the recording of contacts or, potentially importantly, failed contacts with the deceased in the weeks and months prior to a self-inflicted death; (ii) a failure to formally up-date Care Plans and Risk Assessments in a thorough and/or timely fashion, or at all; (iii) inadequate communication with other primary and secondary care providers; (iv) consistently, insufficient attention to the potential clinical significance of 'disengagement' with services by patients; (v) failure to recognise the need to raise issues relating to a patient with the Multi-Disciplinary Team Meetings or in supervision with experienced supervisors. (3) The evidence received in the course of Mr Moore's inquest disclosed that the record keeping of supervision sessions, where a Care Coordinator might seek or be provided with further advice and support from a senior colleague, was incomplete and inadequate. (4) A lack of formal (or even informal) records of the nature, extent or duration of ad hoc *'on the job'/'shadowing'* training, apparently provided to new Care Coordinators. The absence of clear, structured, formal training for the role of Care Coordination allows the issues of concern identified above to be replicated in the care, management and treatment of some of the most vulnerable patients in the community, not least because the present national model of *'shadowing'* and *'on the job training'*, in lieu of formal training, may allow any embedded poor practice to be passed on.
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 05.04.2022. 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: 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** **08.02.2022**