REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Nigel PARSLEY, HM Senior Coroner, for the coroner area of Suffolk.
2.	**DATE OF REPORT** 17 June 2026
3.	**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.
4.	**THIS REPORT IS BEING SENT TO** 1. Secretary of State for Department of Health & Social Care You are under a duty to respond to this report within 56 days of the date of this report, namely by July 28, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6.	**SUMMARY OF CORONER'S CONCERN**

7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	**INVESTIGATION AND INQUEST** On 7th May 2025 I commenced an investigation into the death of Jake Harvey READ aged 29. The investigation concluded at the end of the inquest on 26th May 2026. The conclusion of the inquest was that of: Suicide The medical cause of death was confirmed as: 1a Exsanguination 1b Multiple Self Inflicted Knife Injuries
9.	**CIRCUMSTANCES OF DEATH** Jake Read was declared deceased at 14:42 on the 5th May 2025, at his home address in Melton, Suffolk. When found, a large quantity of blood was seen in his bathroom, and a [redacted] knife was found on the floor. A subsequent postmortem identified that Jake had lacerations [redacted], which by their nature were self-inflicted. Toxicology analysis on blood samples taken from Jake identified that at the time of his death, Jake had no alcohol or any other drugs in his system. On the 3rd May 2025 Jake had attended the Emergency Department of the Ipswich Hospital, requesting support with his Mental Health. Jake was described as being in an agitated state. It was planned to prescribe Jake with a dose of Diazepam after his clinical observations were taken to check there was no contraindication to the dose being given. Following the dose of Diazepam the Mental Health Team planned to speak to him again once he was less agitated. Jake left the Emergency Department prior to being given this medication, and at some later point returned home where he then inflicted knife wounds upon himself.

	In undertaking the actions that he did on or before the 5th May 2025, Jake must have intended his own death, on a background of failing mental health.
10.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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: My primary concern in Jake's case is that evidence heard that there is no national guidance or timelines in place for the administration of medication required in cases where an individual has been identified as being in a state of Mental Health agitation or Mental Health crisis. On the 3rd May 2025 Jake arrived at the Emergency Department of the Ipswich Hospital at 16:36. Jake was identified as requiring a consultation with the Mental Health Liaison Team at 17:05. Two staff from the Mental Health Liaison Team first met Jake at 17:30. At approximately 18:20-1830 it was identified that Jake required a dose of Diazepam to calm his agitation, to allow for a more effective Mental Health Assessment. Prior to administration of the Diazepam clinical observations were required and these were being completed at 18:35. The observations showed no contraindications for the administration of Diazepam. However, the Diazepam was not prescribed to Jake until 21:19, some 2 hours and 44 minutes after the clinical observations had shown no contraindications for the administration of Diazepam. It is believed that Jake had left the Emergency Department at some time between 19:00 and 19:30. It was not possible to identify on the available evidence whether the administration of Diazepam to Jake on the 3rd May would have prevented his death. However, it was acknowledged that there was a chance that had the Diazepam been administered, it might have changed the tragic sequence of events leading to Jake's death. Evidence heard that in some medical cases clinical staff are given a clear timeline in guidance as to when it is expected a required medication is to be administered (sepsis being cited as an example). The court was told that no such guidance exists for the administration of drugs in Mental Health cases. In Jake's case clinical staff stated that had such a timeline been in place, this

	would have prompted staff to prescribe and administer the necessary drug earlier than it was. My second concern is that at the time of Jake's attendance on 3rd May 2025, one of the Mental Health Liaison Team staff who spoke to Jake at 17:30 was a qualified Non-Medical Prescriber, who could have prescribed the Diazepam to Jake herself. However, at that time, even though a Mental Health Liaison Team Non-Medical Prescriber had assessed Jake required an immediate dose of Diazepam, this clinician had no direct access to the required drug. Therefore, at that time, the Non-Medical Prescriber had to request an Emergency Department clinician to prescribe it for them. In Jake's case this caused the 2 hours and 44-minute delay between clinical observations being completed and drug prescription being made. Evidence was heard that the East Suffolk and North Essex NHS Trust and the Norfolk and Suffolk Foundation Trust have changed the system at the Ipswich Hospital, and now the Mental Health Liaison Team Non-Medical Prescribers are able to both prescribe and access prescription medications within the Emergency Department, without the need to request an Emergency Department clinician to prescribe it for them. When asked, the witness providing this evidence could not say whether the same provision was available in hospitals other than those covered by the relevant trusts. As such, it is not known if direct access to Mental Health medication by Mental Health clinicians working in an Emergency Department is just a local arrangement, or if it is replicated in other jurisdictions?
11.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: *[please do not use individual's names, but instead roles/titles]* • [redacted] • **Ipswich and Colchester Hospital (Legal Services)** • **NSFT - Norfolk and Suffolk Foundation Trust (Legal Services)** I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy

	(2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	**SIGNATURE**  **Nigel PARSLEY** **HM Senior Coroner for** **Suffolk**