

## Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This form is to be used **after** an inquest.

<p><b>REGULATION 28 REPORT TO PREVENT DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <p>1 [REDACTED], CEO, Sussex Partnership NHS Foundation Trust</p> <p>2 [REDACTED], CEO, East Sussex County Council</p>
<p><b>1 CORONER</b></p> <p>I, James Healy-Pratt, HM Assistant Coroner for the area of East Sussex.</p>
<p><b>2 CORONER'S LEGAL POWERS</b></p> <p>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.</p>
<p><b>3 INVESTIGATION and INQUEST</b></p> <p>On 23 July 2019 16:17 I commenced an investigation into the death of Rodney John DIXON aged 65.</p> <p>The investigation concluded at the end of a three day inquest on 19 May 2021.</p> <p>The conclusion of the inquest was a medical cause of death of Hanging, and a narrative: This gentleman took his own life, fully intending to do so, after suffering deterioration in his mental health.</p>
<p><b>4 CIRCUMSTANCES OF THE DEATH</b></p> <p>Mr Dixon took his own life at home in Eastbourne, on 15 July 2019, during the course of a Mental Health Act Assessment. He fully intended to do so, following deterioration in his mental and physical health in the preceding weeks.</p>
<p><b>5 CORONER'S CONCERNS</b></p> <p>The MATTERS OF CONCERNS are as follows:</p> <p>Mental Health Act Assessments are conducted in East Sussex deploying clinicians from both ESCC and SPT and independent clinicians such as psychiatrists.</p> <p>The training around Mental Health Act assessments, patient risk management, and their Assessors is sub-optimal. Reasonable access to patient data by independent clinicians for MHA assessments needs to be ensured prior to assessments.</p> <p>I attach my summing up from the Inquest.</p>
<p><b>6 ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action.</p>
<p><b>7 YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 15 August 2021. I, the coroner, may extend the period.</p>

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

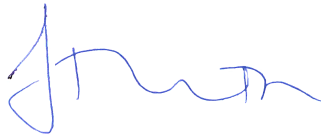
I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:

- The family of Rodney Dixon
- [REDACTED]

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.

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**James HEALY-PRATT**  
**Assistant Coroner for**  
**East Sussex**  
**Dated: 21 June 2021**