REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Essex Partnership University NHS Foundation Trust**
1	**CORONER** I am LINCOLN BROOKES, Area Coroner for the 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 7/5/2020 I commenced an investigation into the death of THOMAS JEFFERY KING (aged 27). The investigation concluded at the end of the inquest on 9/10/2020 The conclusion of the inquest was: Medical cause of death: I a Asphyxia b Hanging CONCLUSION: SUICIDE
4	**CIRCUMSTANCES OF THE DEATH** On 28th April 2020 Mr King was found hanging at his home address in an outside toilet. Paramedics were called but sadly Mr King's death was confirmed at the scene. Police attended and found no evidence to suggest third party involvement in the death. The Court found that Mr King intentionally ended his own life. He had acted impulsively and whilst suffering from very low mood. The Court heard that he had a history of poor mental health which had often deteriorated in moments of crisis linked to his failed relationship with his partner who had obtained a restraining order against him. He had been arrested and sentenced for several breaches of this order (including custody). He also struggled with bereavement following the death of his father. He had been known to mental health services for many years but his contact increased in the months preceding his death whilst coming into contact with the criminal justice system following arrests for the breaches.
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) It was the evidence of the author of the EPUT Root Cause Analysis Investigation Report, [redacted], that whilst all the other EPUT teams that came into contact with Mr King, such as the Mental Health Liaison Team and the Street Triage Team, used the same software called Mobius with which to record, access and share important information and developments regarding Mr King, one Team, namely the Health and Justice Team did not use this software and instead used software that was incapable of being accessed by the other teams. A consequence of this was that the other teams were wholly unaware of

	crises and other important information regarding Mr King's mental health that were known to the Health and Justice Team. (2) Whilst it was the view of the RCA author that in Mr King's case such an obstacle to the sharing / accessing of important information did not have a direct bearing on the outcome for Mr King, she did expressly state, and I share this concern, that there is the potential for the wellbeing and lives of other individuals to be jeopardised where important information and / or crises are known to and recorded by the Health and Justice Team but unknown to all the other relevant Teams. There is the potential for the risk of harm to self and others, including death, to be inaccurately assessed and managed where the assessor does not have access to the full picture. (3) The RCA author was not aware as to why the Health and Justice Team had different software to Mobius or why it was not capable of integration with Mobius, but she felt, and I agree, that action should be taken, if it has not already happened, to explore this issue and to implement a solution.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe **Essex Partnership University NHS Foundation Trust** has 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 4pm 11/12/2020]. 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 Person: [redacted] (mother of the deceased). 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	 **DATE: 15/10/2020**