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LL.B.
Her Majesty's Senior Coroner
for the City of Brighton & Hove
Assistant Coroners
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## CORONERS SOCIETY OF ENGLAND AND WALES

### ANNEX A

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

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

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. Ms. Lisa Rodrigues, Chief Executive, Sussex Partnership NHS Foundation Trust**<br>**2. [redacted] Head of Governance, Sussex Partnership NHS Foundation Trust**<br>**3. [redacted] Legal Support Manager, Sussex Partnership NHS Foundation Trust** |
| 1 | **CORONER**<br>I am Veronica HAMILTON-DEELEY, Senior Coroner, for the City of Brighton and Hove |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 11th November 2013 I commenced an investigation into the death of Danuta Bronislawa CORBETT The investigation concluded at the end of the inquest on18th March 2014.The conclusion of the inquest was **DANUTA CORBETT TOOK HER OWN LIFE WHILST DEEPLY DISTRESSED** |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br>See Record of Inquest |
| 5 | **CORONER'S CONCERNS**<br><br>During the course of 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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>(1) The report concerns the leave policy so far as it relates to Informal Patients.<br>(Copy enclosed – refer to S.4.5 and then S.43).<br><br>(2) Leave was considered first on 1.11.2013 when Mrs. Corbett was on 15 minute observations. The Ward Review documents that she wants leave to go to her home to collect some papers over the next 2 – 3 days- Escorted leave agreed. |

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| | No Leave occurred on 1st, 2nd or 3rd November, 2013 but no reason for this is documented.<br><br>On the 4th she has another Ward Review. She remained on 15 minute observations.<br><br>As to leave, none of the matters referred to in the Policy at S.4.3 are documented in the Progress Note or in the Clinical Review or in the Electronic Note of the ward review on 4th November.<br>In the afternoon of 4th November, Mrs. Corbett repeated her request to the Charge Nurse to go home.<br>She was apparently Risk Assessed again and an escort was allocated. The escort was an agency health care worker who had never met the patient and had never worked on this ward before.<br><br>No note by the risk assessment, or the decision to allow escorted leave was made in accordance with S.4.3 of the Policy. The patient's details and details of the reasons for her admission were not handed over to the escort, in particular neither the fact that her flat/home was central to her distress or the fact that she had threatened to kill herself by jumping from it were known to the escort.<br><br>Thus none of the decisions regarding her Leave on the 4th November are documented.<br><br>This patient jumped out of her 8th floor flat window at home during this escorted leave. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 29th May 2014. I, Veronica Hamilton-Deeley the senior coroner may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons<br><br>1. [redacted]<br>2. Secretary of State for Health, Department of Health<br>3. Sir David Nicholson/Simon Stevens – Chief Executive NHS England<br>4. National Patient Safety Agency<br><br>I have also sent it to:-<br><br>1. Care Quality Commission<br>2. [redacted] - Agency Nurse Hanover Care<br>3. [redacted] - Director of Public Health<br>4. [redacted] - Director of Quality and Primary Care<br><br>Who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 |

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| | publication of your response by the Chief Coroner. |
| 9 | **Date:** **3rd April 2014** **SIGNED BY:** V. Hamilton Teeley<br>**Senior Coroner Brighton and Hove** |
| | |

16/14.
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# Record of Inquest

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|---|---|---|---|---|---|---|
| Following an investigation commenced on the | Eleventh | Day of | November | 2013 | | |
| and an inquest hearing at | The County Court, William Street & The Magistrates Court, Edward Street, Brighton | on the | Twelfth, Thirteenth, Fourteenth & Eighteenth | Day of | March | 2014 |

Before and by (1)me **Veronica HAMILTON-DEELEY** Her Majesty's Senior coroner for **The City of Brighton & Hove and the under-mentioned jurors:-**

**Florence Anderson, Mavis Ang, Hafiz Abdul Butt, Timothy Corner, Sean Dunford, Kenton Hadley, Samantha Ransom, Jackie Stock and Matt Wheeler**

**The following is the record on the inquest (including the statutory determination and, where required , Findings)**

**1. Name of Deceased (if known)**

**Danuta Bronislawa CORBETT**

**2. Medical cause of death**

| | | |
|---|---|---|
| | 1a | HEAD INJURY |
| | b | FALL FROM HEIGHT |
| | c | |
| | 11 | ADJUSTMENT DISORDER ASSOCIATED WITH ANXIETY, DEPRESSION & BEREAVMENT |

**3. How, when and where, the deceased came by his or her death**

SEE ATTACHED SHEET

**4. Conclusion of the Jury as to the death**

DANUTA CORBETT TOOK HER OWN LIFE WHILST DEEPLY DISTRESSED

**5. Further particulars required by the Birth and Deaths Registration Act 1953 to be registered concerning the death**

(a) Date and place of birth
**Eighth October, 1954**
**Sopot, Poland**

(b) Name and Surname of deceased
**Danuta Bronislawa CORBETT**

(c) Sex
**Female**

(d) Maiden surname of woman who has married
**STAWOWY**

(e) Date and place of death
**Fourth November, 2013**
**Roof of The Metropole Hotel, Kings Road, Brighton**

(f) Occupation and usual address
**Architect Widow of Barry Anthony CORBETT ----**
**9a Metropole Court, Kings Road, Brighton**

Signature of HM Senior Coroner V. Hamilton Deeley

Signatures of Jurors

J.M. Stock

RECORD OF INQUEST FOR DANUTA BRONISLAWA CORBETT

3. HOW, WHEN & WHERE, THE DECEASED CAME BY HER DEATH.

ON 04-11-2013 AT THE METROPOLE COURT HOTEL, DANUTA CORBETT A 59YR FEMALE, WHO HAD SUFFERED A SEVERE REACTION TO THE DEATH OF HER HUSBAND AND THE RESULTING CONCERNS AROUND HER HOME AND FINANCES TOOK HER OWN LIFE.

AT THE TIME OF HER DEATH, DANUTA WAS AN INFORMAL PATIENT IN THE LOCAL NHS RUN HOSPITAL ON A PSYCHIATRIC WARD, WITH SUICIDAL IDEATIONS OF JUMPING FROM HER 8TH FLOOR APARTMENT.

SHE HAD REQUESTED HOME LEAVE TO RETURN TO HER APARTMENT TO COLLECT SOME PERSONAL BELONGINGS. THIS LEAVE WAS GRANTED BUT WAS NOT IN LINE WITH THE TRUSTS LEAVE POLICY.

AT THE TIME OF THIS LEAVE DANUTA WAS DOCUMENTED AS 'IN THE RED ZONE' MEANING SHE WAS AT HIGH RISK. SHE WAS ALSO ON 15 MINUTE OBSERVATIONS.

J.M. Stock

# CORONERS & JUSTICE ACT 2009

## Action to prevent other deaths

## Schedule 5

PARA 7(1) Where ----

(a) a senior coroner has been conducting an investigation under this Part into a person's death,

(b) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future and

(c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner must report the matter to a person who the coroner believes may have power to take such action.

(2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it.

(3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner.

## PART 7
## Action to prevent other deaths

### Report on action to prevent other deaths

**28.**—(1) This regulation applies where a coroner is under a duty under paragraph 7(1) of Schedule 5 to make a report to prevent other deaths.

(2) In this regulation, a reference to "a report" means a report to prevent other deaths made by the coroner.

(3) A report may not be made until the coroner has considered all the documents, evidence and information that in the opinion of the coroner are relevant to the investigation.

(4) The coroner—

(a) must send a copy of the report to the Chief Coroner and every interested person who in the coroner's opinion should receive it;

(b) must send a copy of the report to the appropriate Local Safeguarding Children Board (which has the same meaning as in regulation 24(3)) where the coroner believes the deceased was under the age of 18; and

(c) may send a copy of the report to any other person who the coroner believes may find it useful or of interest.

(5) On receipt of a report the Chief Coroner may—

(a) publish a copy of the report, or a summary of it, in such manner as the Chief Coroner thinks fit; and

(b) send a copy of the report to any person who the Chief Coroner believes may find it useful or of interest.

### Response to a report on action to prevent other deaths

**29.**—(1) This regulation applies where a person is under a duty to give a response to a report to prevent other deaths made in accordance with paragraph 7(1) of Schedule 5.

(2) In this regulation, a reference to "a report" means a report to prevent other deaths made by the coroner.

(3) The response to a report must contain—

(a) details of any action that has been taken or which it is proposed will be taken by the person giving the response or any other person whether in response to the report or otherwise and set out a timetable of the action taken or proposed to be taken; or

(b) an explanation as to why no action is proposed.

(4) The response must be provided to the coroner who made the report within 56 days of the date on which the report is sent.

(5) The coroner who made the report may extend the period referred to in paragraph (4) (even if an application for extension is made after the time for compliance has expired)

(6) On receipt of a response to a report the coroner—

(a) must send a copy of the response to the report to the Chief Coroner;

(b) must send a copy to any interested persons who in the coroner's opinion should receive it; and

(c) may send a copy of the response to any other person who the coroner believes may find it useful or of interest.

(7) On receipt of a copy under paragraph (6)(a) the Chief Coroner may—

(a) publish a copy of the response, or a summary of it, in such manner as the Chief Coroner thinks fit; and

(b) send a copy of the response to any person who the Chief Coroner believes may find it useful or of interest (other than a person who has been sent a copy of the response under paragraph (6)(b) or (c)).

(8) A person giving a response to a report may make written representations to the coroner about—

(a) the release of the response; or

(b) the publication of the response.

(9) Representations under paragraph (8) must be made to the coroner no later than the time when the response to the report to prevent other deaths is provided to the coroner under paragraph (4).

(10) The coroner must pass any representations made under paragraph (8) to the Chief Coroner who may then consider those representations and decide whether there should be any restrictions on the release or publication of the response.