	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Lisa Rodrigues, Chief Executive, Sussex Partnership NHS Trust, Swandean, Arundel Road, Worthing, West Sussex, BN13 3EP**
1	**CORONER** I am Penelope Anna Schofield, Senior Coroner, West Sussex
2	**CORONER'S LEGAL POWERS** I make this report under Para 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 23rd May 2013 I commenced an investigation into the death of Ryan Chapman, born on 9th March 1984, being 29 years of age. An Inquest was opened on 23rd May 2013 and was concluded on 16th January 2014
4	**CIRCUMSTANCES OF THE DEATH** On 14th May 2013 Ryan was admitted, as an informal patient, onto the Rowan Ward at the Meadowfield Hospital, Worthing suffering from an undiagnosed mental health condition. On 20th May 2013 Ryan was being accompanied by a peer support worker from the ward to a pottery class. When he got to the reception area of the hospital he took off, left the hospital and ran towards the A27 road. Witnesses then saw Ryan running along the pavement alongside the road when for no reason he changed direction and ran straight out in front of the articulated lorry. It appeared that this was a deliberate act. Ryan subsequently died on 22nd May 2013 at Southampton Hospital from the injuries he had sustained. The cause of death that was reported was that he had died from 1a Catastrophic brain injury and 1b Polytrauma.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise for 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 make this report to you. The MATTERS OF CONCERN are:- 1. **During the course of the evidence it was shown that there a lack of understanding by staff of the Trust's Leave for Non detained patients Policy**. 2. **Staff seemed unclear as whether or not this policy should be applied when patients left the ward to attend activities within the hospital grounds**. It if was to be applied then it was not strictly adhered to in Ryan's case. The Nurse in Charge did not carry out an assessment, as required under Para 4.5., of Ryan at the time he left the ward. 3. **Staff appeared to be unclear as to the role of a Peer Support worker with regards to whether or not they are able to fulfil the role of an escort for patients leaving the ward. The Peer support worker who gave evidence indicated that she did not consider herself an escort but she was a responsible adult who accompanied patients. In Ryan's case the Doctor had approved his leave only when accompanied by an escort. The terminology used in the policy causes this confusion.** 4. **Ryan's Risk assessment and Health Care Plan was not completed within the required period.** This plan was completed two days after it should have been. 5. **There was lack of written information provided to families by the Hospital on admission to help them support their family member.** It appears that this information is at present only given

	to the patient. In addition the family were not provided with a copy of the Ryan's care plan. 6. **There appeared to be a general lack of security on ward with regards to visitors.** There was no consistent signing in procedure and family members could be on the ward without there being a record being kept.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation, Sussex Partnership NHS Foundation Trust can take this action
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely 29th March 2014. I, the Coroner, may extent that period. Your response must contain details of action taken or proposed to be taken, setting out the timeline 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: 1. [redacted] wife of the deceased 2. [redacted] Legal Support Manager, SUSSEX Partnership NHS Foundation Trust 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 representation to me, the Coroner, at any time of your response about the release or publication of your response by the Chief Coroner
9	**DATE:** 31st January 2014 **SIGNED:** [signature]