



Assistant Coroners  
CATHARINE PALMER LL.B (HONS)  
MICHAEL KEEN  
KAREN HENDERSON, BSC, BM, MRCPI, FRCA  
GILVA D.J. TISSHAW, BA (LAW) HONS

Telephone: Brighton (01273) 292046  
Fax: Brighton (01273) 292047

## 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.*

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <ol style="list-style-type: none"><li>1. Chief Executive, Sussex Partnership</li><li>2. Mr. Matthew Kershaw Chief Executive, Brighton &amp; Sussex University Hospital Trust</li></ol>
1	<p><b>CORONER</b></p> <p>I am Veronica HAMILTON-DEELEY, Senior Coroner, for the City of Brighton and Hove</p>
2	<p><b>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>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 10<sup>th</sup> September 2014, I commenced an investigation into the death of <b>Bruce LONGDEN</b>. The conclusion of the inquest was on 17<sup>th</sup>, 18<sup>th</sup>, 19<sup>th</sup> and 20<sup>th</sup> March, 2015</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>See Record of Inquest</p>
5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <p>(1) Sussex Partnership Trust are apparently unaware of their own protocols in connection with :-</p>



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	<p>a) Transfer of Sussex Partnership Trust patients to the acute hospital and b) Observations and Therapeutic Engagement policy</p> <p>These policies were not employed. If they had been the outcome may have been different for Mr Bruce LONGDEN as he would have been specialised and accompanied and would not have had the opportunity to abscond.</p> <p>2) Poor communication within Sussex Partnership Trust and to Brighton &amp; Sussex University Hospital Trust</p> <p>3) Poor communication within Brighton &amp; Sussex University Hospital Trust particularly:</p> <ul style="list-style-type: none"> <li>• Failure to appreciate the significance of Mr Bruce Longden's mental health condition</li> <li>• Failure to understand the terminology used by the mental health liaison team</li> <li>• Failure of the Mental Health Team to adhere to commonly understood terminology</li> <li>• Failure to report the absconson timeously to Sussex Police resulting in a window of opportunity to search for and, potentially, find Mr Bruce Longden to be lost</li> </ul>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>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.</p>
7	<p><b>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 <b>8<sup>th</sup> July 2015</b>. I, Veronica HAMILTON-DEELEY the coroner may extend the period.</p> <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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons</p> <ol style="list-style-type: none"> <li>1. The Chief Executive, Care Quality Commission</li> <li>2. Julian Lee – Chair of Brighton &amp; Sussex University Hospitals</li> <li>3. Secretary of State for Health, Department of Health</li> <li>4. Sir David Nicholson/Simon Stevens – Chief Executive NHS England</li> <li>5. National Patient Safety Agency</li> <li>6. [REDACTED] – Medico Legal Services Manager</li> <li>7. [REDACTED] – Director of Clinical Quality &amp; Primary Care</li> <li>8. [REDACTED] – Director of Public Health</li> <li>9. [REDACTED] – Legal Support Manager</li> </ol>

VERONICA HAMILTON-DEELEY, LL.B.  
Her Majesty's Senior Coroner  
for the City of Brighton & Hove



THE CORONER'S OFFICE  
WOODVALE, LEWES ROAD  
BRIGHTON  
BN2 3QB

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	<p>I have also sent it to:-</p> <p>10. Burnard Brazier Tisdall - Executors 11. [REDACTED]</p> <p>Who may find it useful or of interest.</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p><b>Date:</b> 21st April, 2015    <b>SIGNED BY:</b> [REDACTED]</p> <p>Senior Coroner Brighton and Hove</p>