	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Ms Samantha Allen** **Chief Executive, Sussex Partnership NHS Foundation Trust** **Swandean** **Arundel Road** **Worthing** **West Sussex** **BN13 3EP**
1	**CORONER** I am Penelope Schofield, Senior Coroner, for the area of West Sussex
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 16th June 2017 I (together with a Jury) concluded the inquest into the death of Janet Silva Müller born 25th November 1993 (aged 21 yrs), who died on 13th March 2015. The Jury recorded a narrative conclusion as to the circumstances by which she came by her death. The Jury having found that there were a number of causative failures which led to Janet's death. A copy of the narrative conclusion is attached.
4	**CIRCUMSTANCES OF THE DEATH** On the 13th March 2015 Janet was found in the boot of a burning car. She had died from the inhalation of fire fumes. Janet had been unlawfully killed by [redacted] He has since been convicted of her manslaughter and is currently serving a term of imprisonment of 17 years At the time of Janet's death Janet was a patient at Millview Hospital, Hove. East Sussex. She had been detained under Section 2 Mental Health Act 1983. On two separate occasions on 12th March 2015 Janet had managed to leave the Hospital without permission. The first time she was returned by the Police a few hours later. Sadly it was during the second period of absconding that she was murdered. The Jury were unable to determine by what route Janet had been able to leave Caburn Ward. Although there was some evidence to support that she may have left, on the first occasion, by the Ward entrance doors, and on the second occasion, over the garden wall. The Jury found Janet was at risk of absconding but that there was a lack of communication in relation to this by staff, and there were inadequate risk assessments carried out and documented. Nursing records, handovers, risk assessments and Care Plans were incomplete, insufficient and at times contradictory. In addition there was no record of any observations carried out on Janet for a 12 hour period during 12th March 2015 and following her first absconsion there were no extra measures taken to endure that Janet could not leave the hospital a second time.
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 will occur unless action is taken. In the circumstances it is my statutory duty to

report to you.

The **MATTERS OF CONCERN** are as follows:-

The Jury returned findings of causative failures in relation to

1. **Nursing records, handovers, risk assessments and care plans were often incomplete, insufficient and at times contradictory.** Whilst we were told that regular auditing is carried out by the Trust of nursing records it is clear that this is not fit for purpose as is it did not identify the fact that there were gaps in Janet's nursing records and other key documents. The lack of proper record keeping increased Janet's risk.
2. **The ability of Patients detained under the Mental Health Act 1983 being able to abscond.** Whilst it is accepted that the Hospital has now put in place further measures to prevent patients from being able to abscond from the ward, such as increasing the height of the garden wall and put into additional security around the entrance door, patients have still been able to abscond.
3. **Staffing Levels** – The Jury identified that at times the level of staffing was inadequate and this together with the lack of other measures put in place contributed to the risk of Janet absconding.

I consider that the issues raised in this case should be addressed so that future deaths do not occur in similar circumstances and that action should be taken to reduce the risk of deaths of other patients.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action by addressing these issues.

7 **YOUR RESPONSE**

You are under a duty to respond to this report within 56 days of the date of this report, namely by 29th August 2017. 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 Persons:

1. [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.

DATE: 4th July 2017

SIGNED: Penelope Schofield, Senior Coroner, West Sussex