REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Sam Allen** **Chief Executive** **Sussex Partnership NHS FoundationTrust** **Swandean** **Arundel Road** **Worthing** **West Sussex** **BN13 3EP**
1	**CORONER** I am **PENELOPE SCHOFIELD**, senior coroner, for the coroner 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 4th February 2018, I commenced an investigation into the death of **John Peter RICHARDSON**, aged 60 years. The investigation concluded at the end of the inquest on the 18th December 2018. The Inquest was held with a Jury and they provided the following Narrative conclusion. Since the 15th January 2018, John Richardson had been an informal patient at Maple Ward, Meadowfield Hospital, Worthing; being treated for Recurrent Depressive Disorder and Adjustment Disorder with suicidal thoughts. Although we acknowledge John Richardson intended to take his own life and was admitted as a voluntary patient, we conclude that he did not receive adequate support in a number of areas which could have prevented the circumstances leading to his death. We fully agree with Lorraine Biddell's serious incident review in which she identified 9 key failings; we particularly draw attention to the following: after the initial 72hr care plan, no risk assessment or further care plan was formally created, recorded or communicated for John Richardson; this was not addressed during his stay. Poor oral and written communication and a lack of clarity within that communication, in handovers, care notes and accompanying documents, caused confusion amongst staff and eventually with police following his disappearance. Additionally, minimal communication was made with his family. There was poor record keeping and understanding of trust policy, particularly regarding specific failures to address John Richardson's ongoing risk, the plans for his care, his leave arrangements and the significant events on the 3rd February.
4	**CIRCUMSTANCES OF THE DEATH** On 15th January 2018, John Peter Richardson (known as Sean) was admitted as a voluntary patient to Meadowfields Hospital. At the time of his admission he had been having suicidal thoughts. At about 10.20am on the 3rd February 2018 Sean had gone out for a **walk in the grounds** but he did not return. Staff at Meadowfields contacted Police at 1.06pm to report Sean as a missing person. The Police attempted to locate him but without success. On 4th February 2018 a member of public was walking their dog in some woodlands in Patching when they came across the body of Mr Richardson. Police

	and ambulance were called and death was confirmed by paramedics at 11:09am at the scene. Mr Richardson was found lying on his right side with a ligature around his neck, above him was the other part of the ligature tied around the branch of a tree which appears to have snapped at some point. Police confirmed no suspicious circumstances and no third party involvement.
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. – (1) The Jury in their Narrative Conclusion confirmed that they agreed with the findings in the Serious Incident Report compiled by [redacted] and the 9 key failings by the Trust. However I am satisfied that since John Richardson's death measures appear to have been put in place to address all these issues. (2) However the death of Mr Richardson appears to have occurred when there was some confusion amongst staff with regards to Mr Richardson's leave status. This was identified by the Jury in their conclusion. Whilst some guidance is provided to staff, with regards to voluntary patients taking leave, there is no specific Leave Policy for Voluntary Patients in the same way as there is one for those patients sectioned under the Mental Health Act.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation 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 3rd May 2019. 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:- The family of John Peter Richardson 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	**8th March 2019**  **Penelope Schofield, Senior Coroner**

	West Sussex Coroners Office **County Record Office** **Orchard Street** **Chichester** **PO19 1DD** **Tel: 0330 2227100** **Email: hm.coroner@westsussex.gov.uk**