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 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 6th November 2018 I commenced an investigation into the death of John Ashley, aged 57. The investigation concluded at the end of the inquest on 6th December 2019. The conclusion of the inquest was a Narrative Conclusion namely "John Ashley took his own life whilst suffering a deterioration of his mental illness. His deterioration was not fully appreciated by those treating him within the Sussex Partnership Trust and they failed to provide him with the additional level of care that he required. His death was contributed to by neglect. " Following the Inquest I indicated that I was minded to make a Regulation 28 report but would like to hear submissions from the Interested Persons. An extention for receipt of these submissions was granted to 17th January 2020. I have fully considered the submissions that I have received in preparing this report.

4	**CIRCUMSTANCES OF THE DEATH**
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. Mr Ashley's Care and Treatment Plan was not updated when his mental health deteriorated. 2. Staff were not recording interactions with Mr Ashley in the CareNotes system and often emails were not copied into these notes. Therefore there was a lack of compilation of key information relating to Mr Ashley. 3. There was no system in place for Lead Practioners to be notified of an important entry in a patient's CareNotes where action was required. 4. Mr Ashley had not been seen by a Psychiatrist for over a year and there was no evidence that the deterioration of his mental health (and his non compliance with his medication) had been reviewed by the professionals weekly team meetings. 5. The Inquest identified that there was a discrepanciy in the Trust's own Policies as to when a Risk Assesment should be reviewed. 6. Save for the duty scheme there appears to be no procedure in place for another practictioner to cover a Lead Practictioner's case load or any formal handover when they are on leave. Therefore there was no single person who has uptodate knowledge of a patient who may be in need or whose mental health was deteriorating. 7. The Inquest heard evidence that the Liasion Mental Health Team at the Hosptial did not make use of patient's Care and Support Plans or Central Risk Assessment. 8. The was no clear procedure for GPs to be updated by Care Coordinators with details of a patient's current treatment plan if it had been changed. This was particulary important where there was no regular assessments by a Psychiatrist who would in the normal course of events be providing such updates.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation] have 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 **11th May 2020**. 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:- [redacted] **Sister of the deceased** **Leigh Day, Solicitors for the family** 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	**Date 16th March 2020**  **Penelope Schofield, Senior Coroner**