REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: [redacted] **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 INQU EST** On On September 2019 I commenced an investigation into the death of in Christopher Patrick Swain, aged 38, The investigation concluded at the end of the inquest (which had been held with a Jury) on 12th October 2020. The conclusion of the Jury was a Narrative Conclusion namely "*Christopher Patrick Swain was detained at Langley Green Hospital from 19th September 2019 until the date of his death 22nd September 2019. Chris was found in his room, at Langley Green Hospital having used a ligature around his neck on the evening of 22nd September 2019, where he had committed suicide whilst the balance of his mind was disturbed. During his time at Langley Green Hospital no formal review, care plan or adequate risk assessment was carried out in respect of his mental health. The nursing and clinical records were not kept in accordance with the trust health and record policy, as no adequate risk assessment was carried out prior to the decrease in the level of Chris's observations or at any point during Chris's stay. There was no recorded evidence that any therapeutic engagement has taken place as there is no satisfactory care plan. On the 22nd September 2019, when Chris was found by hospital staff, it is more likely than not he had been deceased for some time. Chris deliberately took his life and intended to do so."* Following the Inquest I indicated that I was minded to make a Regulation 28 report but

	indicated that I would like to hear submissions from the Interested Persons. Submissioss have since been received from those representing the family and those representing the Sussex Partnership Foundation Trust I have fully considered these submissions prior to preparing this report.

4	**CIRCUMSTANCES OF THE DEATH** On 22rd September 2019 Christopher Swain, who had been detained under Section 3 Mental Health Act 1983, was found unresponsive in his room on Coral Ward at Langley Green Hospital having tied a ligature around his neck. . Emergency services were called and CPR was attempted but, sadly, Mr Swain was confirmed deceased by paramedics at 23:54 hours.
5	**<u>CORONER'S CONCERNS</u>** 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. – a) During the evidence there was some confusion amongst staff as to what was required of them when carrying out observations patients in their rooms. There were different practices adopted by different staff and there appeared to be a custom of not enteriing a patient's room on the hourly observations so as not to disturb the patients. Sadly because of this practice it was unclear when Christopher had last been seen alive. Whilst the Trust has indicated that all staff have received further training in respect of this I am still not convinved that it is clear as to what is required by staff. b) Following the evidence the Jury concluded:- (a) that during Christopher's time at Langley Green Hospital no formal review, care plan or adequate risk assessment was carried out in respect of his mental health. (b) that the nursing and clinical records were not kept in accordance with the trust health and record policy. (c) that here was no recorded evidence that any therapeutic engagement has taken place during the period of Christopher's short stay. Whilst the Trust have indicated that there has been a review of the professional conduct of all staff involved in this case this does not allay my concerns that these practices are limited to just those staff involved in this case. c) Failure to provide staff to accompany a sectioned patient to the emergency department of another Hosptial for treatment for a physical condition. Requesting family member to undertake this role puts the patient and/or the family at risk
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 8th February 2021. 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], wife of the deceased.** **[redacted], father of the deceased** 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 14th December 2020**  **Penelope Schofield, Senior Coroner**