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

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

[redacted]

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.*

	THIS REPORT IS BEING SENT TO: 1. [redacted] **- Chief Executive - Sussex Partnership NHS Foundation Trust** 2. [redacted] **Chair of the Board of Governors, Sussex Partnership NHS Foundation Trust** 3. [redacted] **- Sussex Partnership NHS Foundation Trust** 4. [redacted] **– Senior Independent Director - Sussex Partnership NHS Foundation trust**
1	**CORONER** I am Veronica HAMILTON-DEELEY, Senior Coroner, for the City of Brighton and Hove
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 **14th August 2020** I commenced an investigation into the death of **Timothy Julian STEELE** The investigation concluded at the end of the inquest on **10th March 2021**. The conclusion of the inquest was "**HE TOOK HIS OWN LIFE"**
4	**CIRCUMSTANCES OF THE DEATH** **Tim Steele was a 28 year old man with, effectively, a lifelong history of low mood and depression with suicidal ideation. He described his first suicide attempts as taking place before he was 10 years old. He was socially isolated and this was emphasised when he was furloughed from work and spending most of his time alone in his studio flat in Brighton. During 2020he made five or six attempts to kill himself. Prior to that, he had been in the care pf the Children and Adolescents Mental Services, had had an informal admission following suicidality in 2014. Had a further episode of treatment from 2017-2018 and finally came to the attention of Sussex Partnership**

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	Foundation Trust again in May 2020. He registered with a GP in Brighton on the 12th May 2020. The service he received from the GP practice was excellent. From the evidence I FIND that their processes served Tim appropriately until after his assessment on 11th June 2020. The Mental Health practitioner referred him to the East (Brighton) Assessment and Treatment Service following the assessment. He wrote an excellent letter to the GP and copied it to Tim. This explained what Tim could expect but tragically nothing happened. Tim's referral was lost. Tim waited for the expected input. By late on 6th August when asked how he feels, he replies "if anything it's making it worse because of how..... my head feels as a result". On 10th August he died at his home address. See Record of Inquest
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. Steele was lost to ATS follow up apparently due to inefficient processes and a failure to appreciate the urgent need to appoint a Lead Practitioner for him. In particular the focus and delivery of the Care Programme Approach (CPA) as set out in national guidance "Refocusing the CPA- Policy and Positive Practical Guidance" does not appear to have been followed. (2) In addition Sussex Partnership Foundation Trust appears to take a fragmented approach to its policies. Business is conducted in one way in Brighton and in another way, for example, in East or West Sussex and yet patients could be in Sussex depending on availability. They would apparently be dealt with differently depending on their geographic location. At Tim Steele's Inquest it was clear that staff members were not aware o how matters would be dealt with in other parts of Sussex.
6	**ACTION SHOULD BE TAKEN** 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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **5th June 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.

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[redacted]

8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons 1. [redacted] - Father 2. Secretary of State for Health, Department of Health 3. [redacted] Chief Executive, NHS England 4. [redacted] Chief Executive, CQC 5. Dr [redacted], Brighton and Hove CCG, 6. [redacted] – Head of Quality & Nursing CCG Who may find it useful or of interest. 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: 15th March 2021 SIGNED BY:** V. Hamilton-Deeley **Senior Coroner Brighton and Hove**