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], CEO of Sussex Partnership Foundation NHS Trust** **2. [redacted], Deputy Chief Nurse**
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 11th March 2021 I commenced an investigation into the death of Henry James Holcombe. The investigation concluded at the end of the inquest on12th July 2021.The conclusion of the inquest was natural causes.
4	**CIRCUMSTANCES OF THE DEATH** 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) The ongoing failure of SPFT to require their staff to comply with the Trusts therapeutic engagement and observation policy. Especially those sections which relate to night times or when patients are believed to be sleeping (see para 4.5.5, 4.5.7 and table 1 – page 5). Since 27.12.2019 to 5.3.2021 there have

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	been three occasions when patients described as asleep over a series of observations, have actually been found to have been dead for several hours. Serious Incident reports have promised action but nothing effective has been produced.
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 04th October 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 1. [redacted] 2. [redacted], USH NHS Trust 3. Secretary of State for Health, Department of Health 4. [redacted] Chief Executive, NHS England I have also sent it to:- 1. [redacted] Inspector of the CQC 2. Head of patients safety Sussex and B&H clinical commissioning group 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 July 2021** **SIGNED BY:** V. Hamilton-Deeley **Senior Coroner Brighton and Hove**