Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Chief Constable Of Sussex Police** **2 Sussex Partnership Nhs Trust**
1	**CORONER** I am Robert SIMPSON, Assistant Coroner for the coroner area of West Sussex Coroners Service
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 24 March 2021 I commenced an investigation into the death of Jack Stephen TAYLOR aged 26. The investigation concluded at the end of the inquest on 28 January 2022. The conclusion of the inquest was that: Drug related death.
4	**CIRCUMSTANCES OF THE DEATH** Jack was an inpatient detained under a Section 3 of the Mental Health Act at Mill View Hospital. Whilst out on section 17 escorted leave on 17th March 2021, he left the escort and ran away. The Police searched for him but he was not located. On the 19th March, he was found unresponsive at a premises in Worthing, and despite urgent medical assistance, he died at the scene.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) 1. s.18 Mental Health Act 1983 powers & Mill View Hospital. During the inquest Mill View Hospital accepted that it was their responsibility to secure the return of a patient who was detained under s.3 of the Mental Health Act 193 and who had absconded. However I heard that they were often not able to do so without the support of the police. The evidence I heard was that the Psychiatric Intensive Care Unit (PICU), known as the Pavilion Ward, rarely had sufficient staff resources to allow them to send the required minimum of 2 staff members to try and negotiate a return of an absconding patient. I also heard that, if the Hospital considered that the patient would be unwilling to return, it

	would require them to send at least 5 appropriately trained staff members. This would mean that the staffing of other wards would be impacted and also that the Prevention and Management of Violence and Aggression (PMVA) trained team might not be available for any other incidents. In addition the evidence was that the Hospital had no means of transporting a patient in these circumstances. The Pavilion Ward Matron informed me that the ward relied on assistance from the police in relation to all patients who absconded from the PICU. The matron was not aware of any circumstances where Mill View Hospital had utilised its powers under s.18(1) of the Mental Health Act 1983 to authorise in writing 'any other person' to exercise their powers to seek the return of an absconding patient. I am concerned that Mill View Hospital rely solely upon the police to assist them when the police have their own resourcing issues. I am further concerned that the Hospital has not considered the full range of their powers to secure the return of PICU patients who might pose a significant risk of harm, or death, to themselves and/or others after absconding. 2. The joint Sussex Partnership NHS Trust & Sussex Police 'Absent Without Leave (AWOL) Policy' I heard evidence that the risk assessment grading criteria set out in Appendix B of this policy did not match the risk assessment grading criteria for missing persons as defined by the College of Policing. I heard evidence that the policy did not require the PICU staff to provide a copy of an up-to-date risk assessment document or their completed AWOL forms at an early stage when reporting a patient as having absconded. I heard evidence that the PICU staff did not routinely discuss the clinicians' assessment of the grading of the level of risk (i.e. high, medium, low) with the police call-taker nor ask for the police call-taker's decision on such risk level despite it being a requirement of the policy document. I am concerned that the lack of effective joint working may hamper the swift return of high risk patients to the secure environment of the ward which is necessary for their own and others protection. 3. Sussex Police's use of their Missing Persons Policy I heard evidence that the trigger for the interventions required by this policy is that the missing persons report should be transferred onto the Niche system within 2 hours of a unit being assigned to take initial details. In this inquest no units were available to be assigned for over 9 hours due to the high level of demand on both the Brighton and Worthing response teams. Throughout this time the control of the investigation remained with the duty response team. I am concerned that the missing persons investigations are not adequately monitored and progressed due to other demands on the duty response teams attention. I am concerned that opportunities to swiftly locate and return a vulnerable or high risk missing person to the secure ward will be missed when the interventions of specialist officers are not triggered.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 March 28, 2022. 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 Mr Taylor** I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 28/01/2022** **Robert SIMPSON** **Assistant Coroner for** **West Sussex Coroners Service**