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

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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. Chief Constable Giles York - Sussex Police** **2. [redacted] – Sussex Police** **3. [redacted] – Sussex Police**
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 **9th October 2019** I commenced an investigation into the death of **Mr. Thomas REILLY**. The investigation concluded at the end of the Inquest on **13th February 2020**.The conclusion of the inquest was that "**HE TOOK HIS OWN LIFE**"
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) Mr Reilly visited Beachy head on the 1st of October 2019. His intention was to jump off but, when approached by the Chaplains, he changed his mind. Police

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	were called and after discussion and support they saw Mr Reilly safely on his way back to Hove following his car for a while. When the police officer arrived back at Eastbourne police station he raised a safeguarding alert. This alert was sent to the Multi-Agency Safeguarding Hub (MASH). When received there it should have triggered fast onward transmission to the appropriate agency to support Mr Reilly. It was received at MASH at 15.33hrs on the 1st October but, although it had been sent as soon as possible after the incident, it was clear from the evidence that it stood no chance of being dealt with on the 1st. (2) The alerts are graded low, medium and high risk. The high risk alerts stand a chance of being dealt with timeously. This was graded medium which was a reasonable assessment. Everything else will be delayed. Indeed the alert for Mr Reilly was not dealt with until 12:40 hours on Friday, the 4th of October. That is after lunch on a Friday. (3) This alert was not dealt with again until Monday, the 7th of October when it was sent to the mailbox of a named mental health social worker (█████) rather than to the Sussex Partnership Foundation Trust generic mailbox where it would have been actioned on the 7th. As it was, it was received by █████ on the morning of the 8th. She actioned it at once. Too late, Mr Reilly had been found dead early on the 3rd of October. (4) If the alert had been actioned late on the 1st or early on the 2nd of October (as I believe it should have been,) it would have produced an immediate reaction from █████ who would have got in touch with Mr Reilly and arguably her engagement with him may have prevented his suicide. It was clear from the evidence I heard that the system is fundamentally flawed and needs urgent review. In my summing up I found that at the very least there was a missed opportunity to prevent Mr Reilly's suicide and indeed given that his relationship with █████ was good and strong it may well have been the only opportunity to prevent it.
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.

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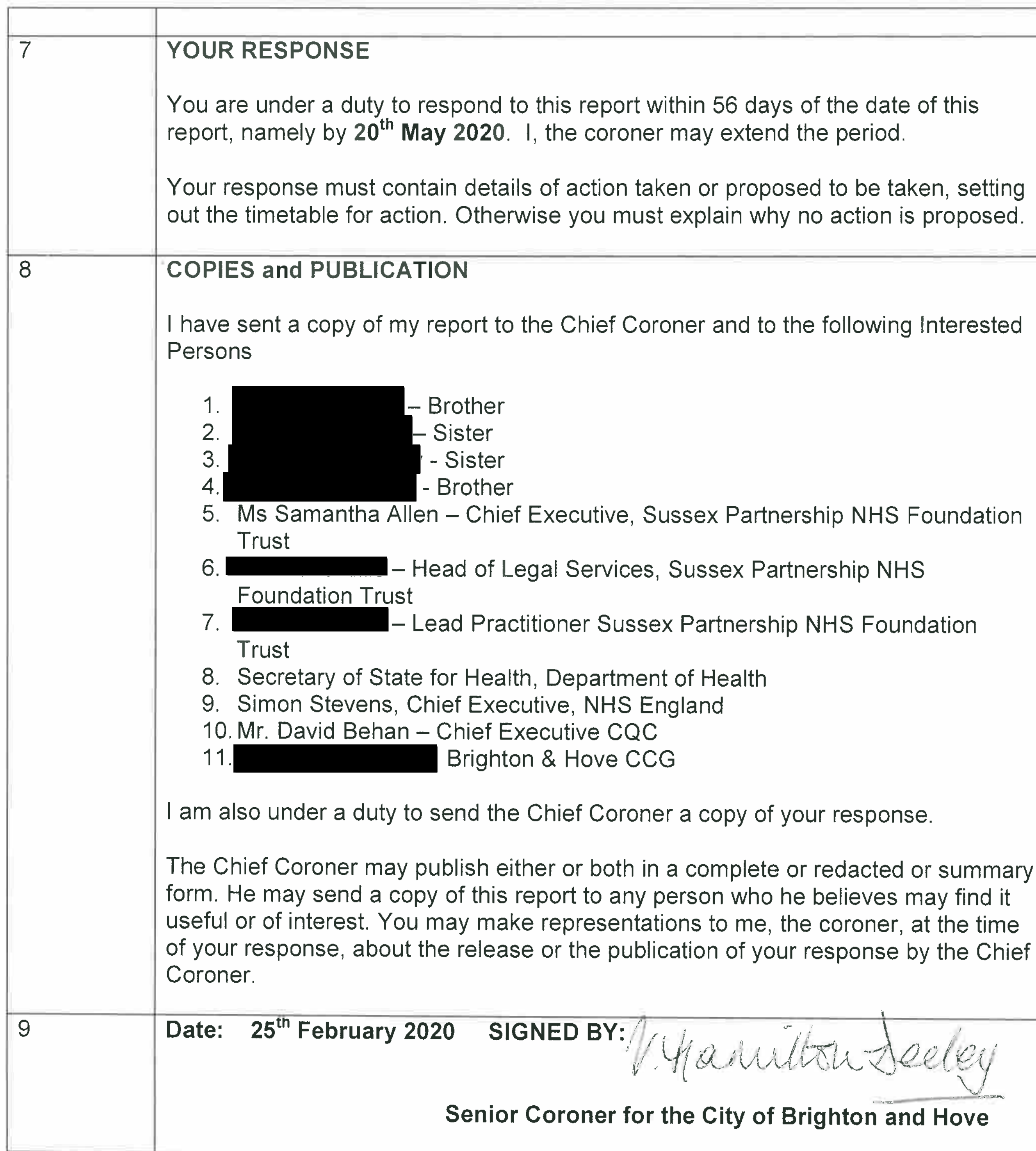

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **20th May 2020**. I, the coroner may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise 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 1. – Brother 2. – Sister 3. - Sister 4. - Brother 5. Ms Samantha Allen – Chief Executive, Sussex Partnership NHS Foundation Trust 6. – Head of Legal Services, Sussex Partnership NHS Foundation Trust 7. – Lead Practitioner Sussex Partnership NHS Foundation Trust 8. Secretary of State for Health, Department of Health 9. Simon Stevens, Chief Executive, NHS England 10. Mr. David Behan – Chief Executive CQC 11. Brighton & Hove CCG 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: 25th February 2020 SIGNED BY:** V. Hamilton-Deeley **Senior Coroner for the City of Brighton and Hove**