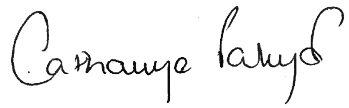
Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1** [redacted] **Brighton and Sussex University Hospitals NHS Trust** **Eastern Road** **Brighton** **BN2 5BE**
1	**CORONER** I am **Catharine Palmer** Assistant 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 INQUEST** On 15th October 2019 an Assistant Coroner commenced an investigation into the death of **Steven Charles Costello** aged **47 years**. The investigation concluded at the end of the inquest on March 19th 2021 The conclusion of the inquest was that: **SUICIDE**
4	**CIRCUMSTANCES OF THE DEATH** Mr Costello developed mental health issues in August 2019. His GP supported him and referred him to primary mental health services. He experienced side effects with some medication and at the time he died he was prescribed Mirtazipine. His mental health deteriorated further so he and his supportive parents attended the Princess Royal Hospital (PRH) A & E department, part of the then Brighton and Sussex University Hospitals NHS Trust (BSUH) at 20.59 on October 3rd 2019. He was triaged and then assessed by a doctor from the Mental Health Liaison Service provided by Sussex Partnership Foundation Trust (SPFT) at approximately 21.30. During the 90 minute assessment he confided confidentially to the doctor that he was suicidal and had a rope at home. She advised him to stay in the hospital for the night (where he felt safe) to be re-assessed the next morning by the mental health team. There was no bed available in the hospital, so he remained in A & E. The Inquest heard evidence that patients in A & E at PRH remain in the care of that department regardless of their health needs. Two sets of notes exist in A & E for patients with Mental Health issues: paper notes in A & E accessible to all staff and Carenotes for SPFT which are electronic and not accessible to PRH staff. The assessing doctor spoke to a nurse and advised the nurse of the plan for his care. No note was made in the paper notes of this plan. He had an unsettled night, there was confusion regarding administering medication so none was given and at approximately 6.15 am on October 4th he was noticed to be missing from A & E. CCTV showed him leaving the hospital. At just after 7.00 am Sussex Police were contacted with a request to conduct a welfare check at his home. After some confusion the check was carried out by officers who believed he was not there. Some short time after the police left, his father attended and found him hanging. The Inquest heard evidence that his paper notes should have been undated by PRH staff every 2-3 hours. They had been completed at initial triage at about 21.00 on 3rd October 2019 but nothing was added until after Mr Costello had left the department on October 4th

	2019. There was no record of his care during this period of time or any written evaluation of his health needs to see if his mental health was declining, improving or remaining stable. Accurate evaluation and review of patients in the department is regarded as vital where needs can change in a very short space of time.
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) Patient notes in the Accident and Emergency Department at the Princess Royal In circumstances where a patient attends A & E at the PRH with a mental health concern they can be seen by a Senior Nurse Practitioner or a Doctor working for SPFT who assesses them; however patient care remains the responsibility of PRH. SPFT have reviewed their practice so that a contemporaneous note of their consultation is copied from Carenotes and placed in the A & E paper notes. Evidence from a PRH witness at the Inquest confirmed that Mr Costello's paper notes should have been updated every 2-3 hours to provide an accurate account of how he was progressing. The witness indicated that the notes themselves which PRH staff use (paper notes) needed updating and reviewing. This had been done previously for the PRH but then discarded following review by a Senior Nurse at the A & E department at Royal Sussex County Hospital which is also run by the same Trust. It is requested that the Trust consider updating the A and E notes on both sites at the very earliest opportunity and to include note of the need to regularly update them in line with policies and that all staff in A & E receive training on the need to complete those notes regularly with emphasis on the importance of recognising the notes as a vital tool in recording and evaluating a patient's condition.
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 **22nd 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] (parents) [redacted] (brother) [redacted] (brother) Sussex Police Sussex Partnership Foundation Trust Brighton and Sussex University Hospital NHS Trust Independent Office for Police Conduct 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: 31/03/2021**  **Catharine PALMER** **Assistant Coroner for** **West Sussex Coroners Service**