REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Gareth JONES, Assistant Coroner, for the coroner area of West Sussex, Brighton and Hove.
2.	**DATE OF REPORT** 26 May 2026
3.	**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.
4.	**THIS REPORT IS BEING SENT TO** [redacted], **Chief Executive, Sussex Partnership Foundation Trust** You are under a duty to respond to this report within 56 days of the date of this report, namely by July 21, 2026. I, the coroner, may extend the period if an appropriate application is made.
5	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6.	**SUMMARY OF CORONER'S CONCERN**

	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) Section 4 contains the jury's findings as revealed in the Record of Inquest. I am concerned that s17 leave is being authorised by staff in ignorance of the leave conditions. In this particular case, the responsible clinician granted leave on the 13th of February 2025, a condition being that Kristian had to test negative for drug use before leave was allowed. On the 15th of February 2025, the nurse in charge granted escorted leave despite Kristian having tested positive for cocaine use. He was unaware of the restrictions on Kristian's leave. Evidence was heard during the Inquest that this was a frequent problem and I am concerned that nursing staff are unaware of leave conditions and this is not being properly monitored. This runs a risk of future fatalities if leave is being granted inappropriately. I am also concerned that staff are not properly able to deal with cardiac arrests in acute mental health wards. In Kristian's inquest, evidence was heard that the response to Kristian's arrest was chaotic and disorganised. Nobody appeared to be in charge, staff were unable to do CPR properly, the 999 call was of a poor standard, there were considerable delays in contacting 999 and the on call doctor and the staff did not have Naloxone training. I had the same issues in an Inquest I did nine months ago in the exact same ward, indeed in the neighbouring room. The fact that the same set of facts have repeated themselves in Kristian's case leads me to a very real concern that future deaths will happen if action is not taken.
7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8	**INVESTIGATION AND INQUEST** An investigation into the death of Kristian Edward Allen was commenced on the 18th of February 2025. Because he was detained under s3 of the Mental Health Act 1983 at the Millview Hospital in Hove it was compulsory for this Inquest to be heard in front of a jury. The jury heard evidence between the 12th of May 2026 and the 21st of May. They reached a conclusion on the 22nd of May 2026. I determined towards the conclusion of the evidence that this is an Article 2 Inquest.
9.	**CIRCUMSTANCES OF DEATH** Kristian Edward Allen had a history of drug and alcohol abuse, and complex mental health issues. He was detained under Section 3 of the Mental Health Act and admitted to Millview Hospital in October 2024. The following factors contributed to the circumstances of Kristian's death on 16th February 2025. Kristian had a Section 17 leave of absence plan created by the responsible clinician

	on 13th February, this plan covered the next 7 days. This included the conditions to be met by Kristian to be permitted leave. These were producing a negative Urine Dip Sample, his mental state being settled, and him taking all prescribed medication. The staff nurse approved Kristian's escorted leave on 15th February despite none of these conditions being met, a history of absconding and a positive cocaine test being recorded. During this leave, Kristian absconded and admitted to taking heroin, cocaine and alcohol. Upon his return to the ward, searches of Kristian were inadequate and not escalated to a more thorough search despite Kristian having absconded and suspicious behaviour being noted by staff. Hospital policy allows for enhanced searches where the risk assessment deems it appropriate. Measures to ensure that no illegal drugs entered the ward were inadequate. Quality of observations were insufficient. Intake of heroin, alcohol and cocaine warranted an increased level of observations from intermittent to eyesight, but only intermittent observations were carried out as part of the care plan determined by the on call doctor and consultant which was then conveyed to ward staff. In addition to this, intermittent observations were not in line with best practise, therefore there were potentially missed opportunities to identify respiratory failure and/or signs of an Regulation 28 – After Inquest Document Template Updated 30/07/2021 overdose. E.g. there was no concern by ward staff to affect an appropriate sleeping position. Paramedics noted that sleeping on your back having taken drugs and alcohol is a risk. Kristian was overheard mentioning to a peer he wanted police and an ambulance at 00:04am on 16th February. There is no evidence that this was investigated by the ward staff. The fact that police and ambulance were not called at this time, is not deemed to be a contributory factor to Kristian's death. Upon finding Kristian unresponsive at 5:05am, there were delays in the response by the ward and medical staff. These were: a 10 minute delay in phoning an ambulance (called at 5:15am), 13 minute delay in phoning the on call dr (called at 5:18am), a delay in pulling the emergency alarm, a delay in using the defibrillator, attempting to place an I Gel and administering Naloxone. There was a lack of clear organisation and communication when coordinating the response to finding Kristian unresponsive which contributed to all the delays. There were communication issues noted repeatedly in relation to Kristians' substance intake, which would have impacted decision making by hospital staff. The paramedics observed substandard CPR administered by Millview staff. With the positioning, depth and timings being incorrect. In the Patient Safety Incident Investigation report, it was noted that 95% of staff were up to date on CPR training provided by the trust. Narrative Conclusion Narrative At 6am on 16th February 2025, Kristian Edward Allen was declared deceased due to heroin toxicity at Millview Hospital. Controls on granting Kristian leave failed to be implemented, searches were inadequate given the level of risk through his substance history and known drug use within the ward. The level of observations were insufficient given Kristian's admitted drug and alcohol intake. The emergency response to finding Kristian unresponsive and the subsequent actions taken were not effective and contributed to the

10	circumstances of Kristians death. There were multiple systemic failings in staff adhering to trust policy and procedures, inadequate training in response to a drug overdose and widespread poor communication within the ward. **COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: Mr Allen's family The Chief Constable of Sussex Police South East Ambulance Service (SECAMB) I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
11.	**SIGNATURE**  **Gareth JONES** **Assistant Coroner for** **West Sussex, Brighton and Hove**