IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Sebastian NOTTAGE
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive Surrey and Sussex Healthcare NHS Trust Trust Headquarters East Surrey Hospital Canada Avenue Redhill RH1 5RH
2	**CORONER** Miss Anna Crawford, HM Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
4	**INQUEST** The inquest into the death of Sebastian Nottage was opened on 14 July 2020. The inquest was resumed on 11 March 2022 and the conclusion was handed down on 18 March 2022. The medical cause of his Nottage's death was: 1a. Multiple injuries and electrocution The inquest concluded with the following narrative conclusion: On 30 June 2020 Sebastian Nottage died on the railway line between Salfords Station and Earlswood Station, having sustained fatal injuries as

	a result of being hit by a London bound train. Prior to his death, he [redacted] tripped and fell into the side of the train, resulting in his death. [redacted].
5	CIRCUMSTANCES OF THE DEATH Sebastian Nottage was 26 years old and had Asperger's Syndrome and Attention Deficit Disorder. He also had a history of Anxiety, Insomnia, and Opioid Dependence. On 29 June 2020 he was admitted to East Surrey Hospital where he was treated for acute pancreatitis. He was seen initially in the Emergency Department and then in the afternoon he was transferred to Tandridge Ward, which is the Surgical Assessment Unit. Shortly before 8am on the morning of 30 June 2020 he left Tandridge Ward without telling any members of staff that he was doing so. Thereafter he made his way to the railway line between Salfords Station and Earlswood Station where he sustained fatal injuries as a result of being hit by a London bound train. The court heard that a 'Seven-day short stay booklet for admission/discharge' is completed when a patient is admitted to Tandridge Ward and that the booklet seeks and records information in relation to a variety of topics which are pertinent to a patient's care. The court found that there was an omission to complete fully the booklet at the time of Sebastian's admission to the Surgical Assessment Unit and thereafter. The court also found that the admitting nurse relied on information recorded in the Emergency Department notes (some aspects of which were incomplete) to complete some parts of the booklet and did not check the information with Sebastian or his mother who was accompanying him. The court accepted the opinion of the Court's expert

	nursing witness, that these matters fell below expected standards of nursing care, albeit they did not cause or contribute to Sebastian's death. The Court heard evidence from [redacted] the Trust's Head of Nursing. She gave evidence, amongst other things, that: (i) She could not assist with whether there are any formal policies presently in place in relation to the timeframe in which the booklet ought to be completed, but said that in her professional opinion it ought to be completed in full within 24 hours of admission to the unit. (ii) She did not consider that the booklet should be handed over to night staff to complete, if it was not fully completed on the day of admission. This differed to the view of the Court's expert nursing witness. (iii) She considered that it was appropriate for the booklet to be based in part on information which had previously been recorded in the Emergency Department notes without checking it directly with the patient. Again, this differed to the view of the Court's expert nursing witness.

6	**CORONER'S CONCERNS** The Coroner's concerns are set out below. The **MATTER OF CONCERN** is: - There is no clear guidance in place in relation to the timeframe for the full completion of the 'Seven-day short stay booklet for admission/discharge' and the steps to take if the booklet has not been fully completed on the day of admission to the unit. The Coroner considers that further guidance and/or training on this matter may be required. - There is no clear guidance in place in relation to the manner in which the 'Seven-day short stay booklet for admission/discharge' ought to be completed, and particularly whether it is permissible to rely on information recorded in the Emergency Department without checking it directly with the patient. The Coroner considers that further guidance and/or training on this matter may be required.
7	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
8	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.

9	**COPIES** I have sent a copy of this report to the following: 1. Chief Coroner 2. Sebastian Nottage's family 3. Network Rail
10	**Signed:** **Anna Crawford** **H.M. Assistant Coroner for Surrey** **Dated this 19th day of April 2022**