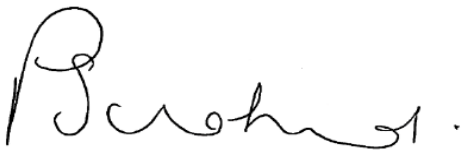
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Chief Executive** **Sussex Partnership NHS Foundation Trust** **Arundel Road** **Worthing** **West Sussex** **BN13 3EP**
1	**CORONER** I am **Penelope Schofield**, Senior Coroner, for the coroner area 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 21st February 2022 I commenced an investigation into the death of Caroline Victoria Forte aged 35 years. The investigation was concluded at the end of the Inquest on 14th March 2023. The Inquest was held with Jury. The conclusion of the Jury was a narrative conclusion namely: "Caroline Victoria Forte died as a result of suicide at [redacted], Brighton on 20th February 2022. She had a provisional diagnosis of severe depression with psychotic symptoms. Caroline was detained under Section 2 of the Mental Health Act. The following factors contributed to her death:- 1. Inadequate communication within Amberley Ward. 2. Inadequate communication between Amberley ward and Caroline's family. 3. No evidence of an overnight care plan or risk assessment prior to leaving the ward. 4. Failure to follow the section 17 leave of Absence policy."
4	**CIRCUMSTANCES OF THE DEATH** Caroline had been struggling with her mental health for some time following the breakdown of a relationship. Since 27th January 2022 she had been receiving treatment as an inpatient (under Section 2 Mental Health Act 1983) on the Amberley Ward at the Department of Psychiatry, Eastbourne Hospital. On 18th February 2022 she was granted Section 17 weekend leave to take place at her parents address. Sadly on 20th February she was found hanging [redacted]
5	**CORONER'S CONCERNS**

	During 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:- The Jury in their findings found the following matter contributed to the death of Caroline namely 1. Inadequate communication within Amberley Ward. 2. Inadequate communication between Amberley ward and Caroline's family. 3. No evidence of an overnight care plan or risk assessment prior to leaving the ward. 4. Failure to follow the section 17 leave of Absence policy. During the course of the evidence we heard that:- a) The daily care log was not completed so it was not possible to ascertain who was the last person to see Caroline leave the ward. b) There was no record to show which nurse carried out a risk assessment before she left. c) There was no overnight care plan. d) The “My care and safety plan” had not been updated with regards to “My family will do” section. e) The family were not provided with a copy of the Section 17 leave form f) At the time of this leave the family were unaware that Caroline had self-harmed in the hospital by tying a ligature. Therefore, the family told the Inquest that they therefore had no strategies in place to minimise the risks of such an event. Similarly there was no communication with the hospital as to how to minimise Caroline’s risk. f) Senior Officers from the ward showed a lack of knowledge of the Trust’s own Section 17 leave policy and Safe and Effective Assessment & Management of Clinical risk: Risk Management Police and Procedure.
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 23rd June 2023 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 Caroline Forte 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 27th April 2023**  **Penelope Schofield** **Senior Coroner, Brighton and Hove**