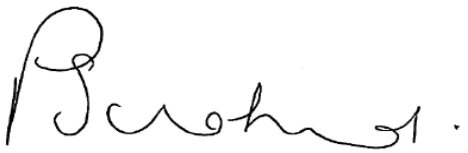
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Chief Executive, NHS England, Wellington House 133-135 Waterloo Road, London, SE1 8UG.** **2. [redacted] Chair, Integrated Health Board NHS Sussex, Wicker House, High Street, Worthing, BN11 1DJ.**
1	**CORONER** I am **Penelope Schofield**, Senior Coroner, for the coroner area of West Sussex, 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 30th July 2020 Ms Hamilton-Deeley, the former Senior Coroner, commenced an investigation into the death of Rachel Kathleen Garrett aged 22 years. The investigation was concluded at the end of the Inquest on 2nd June 2023. The conclusion given was a narrative conclusion namely: Rachel, who was suffering from a complex mental health disorder, took her own life having suffered a deterioration of her mental health in the preceding months. Despite the extensive support of her family and the care being provided by the Mental Health services they had been unable to keep her safe. There was a missed opportunity to prevent her from leaving the Royal Sussex County Hospital on the second occasion on the 29th July 2020.
4	**CIRCUMSTANCES OF THE DEATH** Rachel had been struggling with her mental health for some time, but there had been a marked deterioration in July 2020. She had, on a number of occasions, been found close to the cliff edge in and around Brighton. On each occasion she was either detained by the Police under Section 136 Mental Health Act 1983 or voluntarily agreed to attend A&E at the Royal County Sussex Hospital. On 28th July 2020 Rachel had again been found on the cliff edge. She was detained under Section 136 Mental Health Act and was again taken to A&E in Brighton. Before a mental health assessment could be carried out, she absconded from the hospital and returned home.

	In the early hours of the 29th July her parents contacted the ambulance service as they felt unable to keep Rachel safe. She was returned to A&E where she was later seen by the Mental Health Liaison team. Throughout her time in A&E she was nursed by an HCA on a 1 to 1 basis. Although Rachel was found not to be detainable under the Mental Health Act the Consultant Psychiatrist, who was part of the Mental Health Liaison Team, had recommended that if she decided to leave the Hospital again, that consideration should be given to the use of the Doctor's holding power under Section 5(2) Mental Health Act. Sadly, Rachel did leave the hospital for a second time and went back to the cliffs where she ended her life by falling from the cliff top.
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:- Patients who attend a Hospital Accident and Emergency Department with mental health difficulties are in most hospitals seen by a Mental Health Liaison team (made up of Consultant Psychiatrists and Mental Health nurses) These staff are not employed by the Acute Hospital Trust but are employed by a local Mental Health Trust (in this particular case it was the Sussex Partnership Foundation Trust). As a result of their employment status the Mental Health Liaison team (who have the best knowledge of the patient having been caring for them) cannot invoke the Doctors or Nurses holding powers under Section 5(2) Mental Health Act (Section 5(4) for nurses). If a patient decides to abscond from the Acute Trust Hospital the Mental Health staff cannot detain/hold the patient. They would have to ask a Doctor within the Acute Hospital to do so. This Doctor may not have any knowledge of the patient and would be unlikely to act immediately in a busy A&E. By that time the patient would have been long gone. Due to this technical issue around the employment status of the Mental Health Team, those suffering with a deteriorating mental health in an acute setting are at risk in these circumstances.
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 August 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 Rachel Garrett** • **University Sussex Hospital NHS Foundation Trust** • **Sussex Partnership Foundation Trust** • **Royal College of Psychiatrists** • **Secretary of State** • **Chief Executive CQC** 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 June 2023**  **Penelope Schofield** **Senior Coroner, West Sussex, Brighton and Hove**