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 Langford Centre** **2 NHS England**
1	**CORONER** I am Laura BRADFORD, Assistant Coroner for the coroner area of East 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 19 May 2022 I commenced an investigation into the death of Christopher Richard ALLUM aged 36. The investigation concluded at the end of the inquest on 08 November 2023. The conclusion of the inquest was that: Christopher Richard Allum died as a result of suicide.
4	**CIRCUMSTANCES OF THE DEATH** Christopher Richard Allum had a history of escalating mental health issues from March 2022. On 26 March 2022 he attended A&E [redacted]. He reattended hospital on 28 March 2022 after a further incident of deliberate self-harm [redacted]. He presented to hospital again on 29 March with suicidal ideation and a further incident of deliberate self-harm. On 23 April 2022 whilst in a ward setting, Christopher [redacted] in an attempt to be suspended. Christopher was later discharged and on 9 May 2022 he disclosed to mental health professionals that he [redacted]. On 11 May 2022, he self-harmed again at his home address [redacted]. He was admitted to hospital and on 13 May 2022 he disclosed to a member of staff that he had [redacted]. These previous incidences were recorded in Christopher's care notes. Christopher was admitted to the Langford Centre on 14 May 2022. His risk of suicide and self-harm was rated as high at the time of admission. The referral paperwork received by the Langford Centre made reference to the previous incidences of cutting and drinking of corrosive substances but did not mention ligatures. Christopher's care notes were not accessed by staff at the Langford Centre until after his death. There was no record of Christopher arriving at the Langford Centre with a belt, nor any record of a belt being within his possession nor taken from him at any stage. On the evening of 15 May 2022, Christopher was found unresponsive in his room [redacted] Paramedics were called and CPR was attempted, however, it was not possible to revive Christopher and death was confirmed at 23:01.

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) Initial referral – there seems to be a gap at the initial referral and admission stage in obtaining information about and recording previous methods of self-harm and suicide. There also appears to be a gap in the seeking and recording of relevant information from an individual's family at the point of referral and admission. An individual's family is often able to provide detailed and useful information about events that may not have been previously reported and/or be able to bridge the gap in communications between various health agencies involved in someone's care. Access to notes - the other concerning issue is the difficulty prevalent within the private sector in the accessing of NHS notes. It appears to be the position across the private sector that access to an individual's notes is not provided as standard. This means that there may be a significant gap in the information available when someone is admitted to a premises run by a private healthcare provider, even within an NHS allocated bed. This gap in information can have an impact on an individual's risk assessment and their subsequent care plan.
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 January 03, 2024. 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] I have also sent it to the Sussex Partnership NHS Foundation Trust who may find it useful or of interest. 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: 10/11/2023**  **Laura BRADFORD** **Assistant Coroner for** **East Sussex**