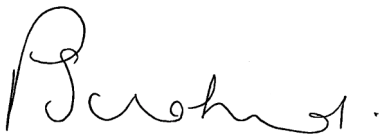
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1** [redacted] **Secretary of State for Health and Social Care** **39 Victoria Street** **London** **SW1H 0EU**
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 18 May 2022 I commenced an investigation into the death of Jessica Zoe EASTLAND-SEARES aged 19. The investigation concluded at the end of the inquest on 01 December 2023. The inquest was held with a Jury. The conclusion of the Jury was: "It is the conclusion of the Jury that systematic failures in Health and Social care led to a series of events, which caused the deceased periods of dysregulation culminating in regular bouts of self-harm, which ultimately ended in death by misadventure."
4	**CIRCUMSTANCES OF THE DEATH** At 01.16 am on 17th May 2022 Jessie was pronounced deceased at Caburn ward, Millview Hosptial, Hove. East Sussex. She had been found with a ligature tied around their neck. Jessie had been diagnosed with Autistic spectrum disorder, ADHD, Complex traumatic stress disorder and emotional unstable personality disorder. Following a breakdown in the provision of her support package Jessie's mental health deteriorated and was detained under Section 3 Mental Health Act 1983. She remained in Hospital from 4th March 2022 until the time of her death.
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: Sadly this case exposes the total inadequate level of community provision for the care and treatment of those with suffering with Autism. This is a national problem and sadly leads to

	many experiencing unnecessary admissions to inpatient mental health facilities and also A&E attendances. Despite a report from the Health and Social Care committee from 2021 this case showed that there does not seem to have been any real improvement and more lives are likely to be lost. Reading from this report, it says "The conclusion of this report was that Autistic people (and people with learning disabilities) have the right to live independent, free, and fulfilled lives in the community and it is an unacceptable violation of their human rights to deny them the chance to do so." The report identified that "the community support and provision for autistic people (and those with learning difficulties) and financial investment in those services is significantly below the level required to meet the needs of those individuals and to provide adequate support for them in the community. " The Inquest heard that two years on there still remains an acute shortage of provision. Evidence was heard that East Sussex Council had tried over 30 providers to help put in place support for Jessie but they could not find a placement for her so the only provision that they were able to offer her was supported housing with temporary care agency staff. This provision broke down which exsacerbated Jessie's mental health. This then led to a Hosptial mental inpatient admisssion.
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 February 04, 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] [redacted] **Sussex Partnership NHS Trust** **East Sussex County Council** **Brighton and Hove City Council** 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: 10/12/2023**  **Penelope SCHOFIELD** **Senior Coroner for** **West Sussex, Brighton and Hove**