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) The Secretary of State for Health and Social Care. (2) NHS England. (3) National Institute for Health and Care Excellence (NICE).
1	**CORONER** I am MICHAEL SPENCER, HM 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 26 September 2023 I commenced an investigation into the death of Nicolette Elizabeth McCARTHY aged 46. The investigation concluded at the end of the inquest on 08 November 2024. The conclusion of the inquest was a narrative conclusion as follows: **Nicolette Elizabeth McCarthy died as a result of suicide due to her acute mental ill health and a series of contributory factors. There were a series of failures in the systems and procedures which should have guaranteed her safety.**
4	**CIRCUMSTANCES OF THE DEATH** The jury made the following findings of fact in Box 3 of the Record of Inquest: Nicolette Elizabeth McCarthy was detained to the Woodlands secure unit - under the Mental Health Act - Section 5(2) for concerns of her own safety following attempts to take her life. On the 18th and 19th September there remained a risk that she may attempt to end her own life. On 18th September 2023, Nicolette's family attended the ward round discussion, there is no evidence that confirmation of escorted or unescorted leave was delivered to them. Any ambiguity could have been avoided if Trust procedures had been followed, written confirmation of the S17 decision provided and acknowledged by the family. It was appropriate to grant in principle unescorted S17 leave but not implement it until written confirmation was provided to the family and the risk assessment updated. Nicolette should not have been required to leave unit grounds. Although the NHS/Sussex Trust have a policy that no smoking should take place within the grounds, there should have been provisions that within secure units secure smoking facilities or indeed an exemption should have been made. As per the Trust's "Record of Patient leave" form, checks and consideration should have been given to the appropriateness of any items Nicolette had on her person for the leave being taken. As per the Trust's concession, the Trust did not take immediate action, aligned to Nicolette's individual clinical risk, when Nicolette did not return to the ward, following her

	15 minutes leave (starting at 14:37) on 19 September 2023. The failure to mark Nicolette as AWOL rather than on leave added to the confusion and highlighted gaps in the record keeping. Although staffing levels were low and incidents on 19th September 2023 further impacted staff availability, there was a failure to take steps as outlined in Trust policies following identification of Nicolette's absence. There were further factors in play: 1) insufficient adherence to recording patient login time in the procedure on the S17 leave sheet. 2) unacceptable delays in taking appropriate action on 19th September. 3) the Trust's adherence to robust note keeping/updating appears to have been lax and retrospective at times. It is possible that on 19th September 2023, had staff taken prompt action there would have been opportunities by which Nicolette's death could have been avoided
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: 1) During the course of the inquest, I heard evidence from clinicians and staff at the Trust to the effect that the NHS England smoke free policy is placing mental health in patients at an increased risk from self-harm and suicide. 2) Although smoking cessation advice and treatment (e.g. gum, vapes etc.) are routinely offered to patients, the evidence was that many struggle to give up smoking on their admission to the ward, in part because the anxiety associated with stopping exacerbates their mental health symptoms. Staff also felt that forcing patients to stop smoking against their will (e.g. by prohibiting them from smoking while on leave) would have a negative effect on their sense of autonomy and wellbeing, which are important for recovery. 3) The Trust understand that they are bound by the Health Act 2006 and by NHS England policy not to permit or facilitate smoking on the ward or anywhere on the grounds of the hospital. This is taken seriously and is interpreted to mean that staff are prohibited from facilitating smoking, for example by granting leave for the purpose of smoking or by escorting patients to smoke outside on short periods of leave. Senior staff also believed that it would be contrary to NHS policy to permit smoking in a secure area, for example the enclosed ward garden. At the same time, it was acknowledged that patients would inevitably seek leave to smoke and that this could not be denied without a negative impact on their mental health. 4) The jury heard evidence that patients, like Mrs McCarthy, were routinely given 15-minute grounds leave for the purpose of smoking, a practice that is discouraged by the Trust. Clinical staff felt that the policy placed them in a difficult position, torn between the need to comply with the smoke free policy, while also supporting patient autonomy and keeping safe those patients who are at a higher risk of self-harm or suicide. 5) There is a further contradiction caused by the smoke free policy, in that patients are not permitted to smoke on the grounds, but are not supposed to leave the grounds during short periods of 'grounds' leave. The result is that patients would spend their 15-minute leave smoking by the side of the road on the edge of the ward grounds, which is a poorly supervised area, and staff would avoid asking them too closely where they were going and would avoid standing close to them, even

	when smoking themselves. This contributed to the circumstances that allowed Mrs McCarthy to slip away unnoticed and ultimately to take her own life. 6) I also heard evidence from senior staff that the national policy guidance intended to address smoking and s17 leave (e.g. the NICE Guidance and CQC Guidance) does not adequately resolve these contradictions. 7) I am concerned that the NHS smoke free policy, while clearly motivated by a genuine and pressing concern to protect life and promote health, may not be adequately tailored to reflect the safety requirements of mental health wards or the reality that some mental health patients will inevitably seek short periods of leave to smoke. Action may need to be taken at the national policy level to provide clearer guidance and/or review the law to reduce the risk of patients in mental health wards absconding while on unescorted grounds leave.
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 17 January 2025. 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 (1) Mrs McCarthy's family. (2) 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: 22/11/2024**  **Michael SPENCER**

	Assistant Coroner for **East Sussex**