**Regulation 28: REPORT TO PREVENT FUTURE DEATHS**

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

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| | **REGULATION 28 REPORT TO PREVENT DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>• **Chief Executive Integrated Care Board** |
| **1** | **CORONER**<br><br>I am Penelope Schofield, Senior Coroner, for the coroner area of West Sussex and Brighton and Hove |
| **2** | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 23rd November 2022 I commenced an investigation into the death of Matthew Zak Sheldrick (Matty). Matty identified as non-binary and preferred the use of the pronouns they and them.<br><br>The investigation concluded with the Inquest being held over a two-week period which concluded on Friday 13th December 2024.<br><br>At the end of the Inquest, I concluded that:<br><br>On 3rd November 2022 at around 02.21 Matty had attended Accident & Emergency at the Royal Sussex County Hospital in crisis following a further deterioration in their mental health. This was the second admission in no less than 5 weeks. During this second admission they were experiencing intense suicidal thoughts.<br><br>Later on 4th November 2022 they were formally assessed under the Mental Health Act and the decision taken was not to detain them. Provision was however made for Matty to be able to stay in the hospital that night if they wished.<br><br>However, Matty left shortly afterwards and tied a ligature around their neck and suspended themself from [redacted] |

[redacted]. Their intentions at the time of carrying out this act remain unclear.

The following issues contributed to their death:-

1. The fact that Matty's private housing accommodation, which had been arranged following their move to Brighton, was not suitable due to their ongoing sensory issues.
2. The fact that there had been no psychiatric bed available to Matty during their first admission to Accident and Emergency Department in September. They stayed in the Accident and Emergency department for 26 days during their admission between 5th and 30th September 2022. This meant that there was no meaningful therapeutic input at that time.
3. The fact that Accident and Emergency Department was not a suitable environment for a neurodivergent individual and the 26-day period of their stay contributed to the deterioration of their mental health difficulties.
4. The fact that there was a general lack of inpatient bed provision for informal patients and in particular for those who are autistic and non-binary who require to be on a mixed ward.
5. The fact that Matty was discharged from the Crisis Resolution Home Treatment Team on 18th October 2022 before being picked up by Assessment and Treatment Service. This left a gap in service provision for Matty.
6. The rigidity of the referral process to Transforming Care in Autism team (TCAT) meant that Matty was unable to access specialist advice and resources whist in A&E or in the community.
7. The fact that the mental health assessment carried out during this second admission did not take into account the following:-
   - The views and observations of the nearest relative, Matty's mother. - Matty's preferred communication aids and in particular Matty's communication book.
   - The need for Matty to have an advocate present during the assessment and give consideration to the use of idiosyncratic language.
   - The extent of Matty's deteriorating mental state and their increasing risks in the context of their neurodivergence.
   - The fact that Matty's change of behaviour during the assessment may be due to:-
     a) the fact that Matty had been given diazepam
     b) the fact that Matty may have been able to mask their distress.
   - Too much emphasis was placed on Matty's presentation within the assessment itself.
8. There was a lack of discharge care planning documented after the assessment on 4th November 2022 particularly if Matty decided to leave before the morning. This led to confusion within the A&E department when Matty decided to leave the hospital.

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| | **BRIEF CIRCUMSTANCES OF THE DEATH**<br><br>Matty had struggled with their mental health throughout their adult life, but it wasn't until 2019 that Matty was finally diagnosed with Autism. ADHD and Autistic Spectrum Disorder. However, they had never been sectioned under the Mental Health Act or had spent time as a voluntary patient in a mental health hospital.<br><br>Matty had moved to Brighton from Surrey in November 2021 having wanted to live independently. They were drawn to Brighton as they wished to be involved in the trans/non-binary community.<br><br>Matty's mental health deteriorated during the summer of 2022 due to accommodation issues that they had been facing and issues with an online relationship. By 3rd September they were in crisis.<br><br>On 5th September 2022 Matty was admitted to A&E at the Royal County Hospital, Brighton. They remained within A&E, short stay ward, for 26 days awaiting a psychiatric bed. During this time no bed was found, and they were eventually discharged back home with support from the Crisis Home Treatment Team. Matty's mental health had been affected by the unsuitability of the environment within A&E for someone awaiting an inpatient mental health bed.<br><br>Less than 5 weeks later Matty was again admitted to the A&E department at the Royal Sussex County Hospital on 3rd November 2022 in crisis. Their presentation fluctuated and this led to them being assessed under the Mental Health Act. However, they were not found to be detainable. They left the hospital shortly after the assessment and were sadly found hanging in the grounds of the hospital. |
| **5** | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows:<br><br>1. The lack of inpatient beds leading to the unacceptable wait time in A&E for those suffering with their mental health who are awaiting beds. In Matty's case a bed was not found for them within a 26-day period.<br>2. There being a shortage of beds for Autistic patients (both informal and detained) within the private sector that are being funded by the |

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| | ICB. Evidence was heard that those providing beds within the public sector very often refused to accept autistic patients due to their additional risks.<br>3. There being a shortage of beds for transgender patients who are in need of a mixed ward.<br>4. In Matty's case it appears there was a lack of appreciation by the ICB of his extensive length of stay in A&E. It appears that this information (and others who had lengthy stays) was not at that time being collected, monitored and acted on by the ICB.<br>5. The unsuitability of the environment of A&E as a holding place for those in need of a mental health bed. The evidence was that the environment in A&E as a holding place is not conducive for those suffering with Autism and/or who are neurodiverse. The environment in A&E can exacerbate and cause further deterioration in their mental health.<br>6. There is a gap in services for those who are not ill enough to be detained but who are too high risk to be sent home.<br>7. There is a significant wait time for referral to the Assessment and Treatment Service. Therefore, any therapeutic input is delayed, and this results in repetitive attendances at A&E when in crisis.<br>8. Current gaps in service around psychosocial support for transgender, non-binary and intersex adults have been provided by third party charitable organisations. It is understood that much of their funding has recently been withdrawn by the ICB. This is of particular concern as Brighton is recognised as having one of the largest trans communities in the Country |
| **6** | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report,<br>namely by 10th February 2025 I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:- |

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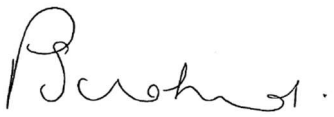
| | **a) The family of Matty Sheldrick**<br>**b) Sussex Partnership Foundation Trust**<br>**c) Brighton and Hove City Council**<br>**d) University Hospital Sussex Trust**<br>**e) GP Practice - WellBn**<br>**f) The Clare Project**<br>**g)** [redacted]<br><br>I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.<br><br>I may also send a copy of your response to any person who I believe may find it useful or of interest.<br><br>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.<br><br>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: 16/12/2024**<br><br>  <br><br>**Penelope SCHOFIELD**<br>**Senior Coroner for West Sussex, Brighton and Hove** |