University Hospitals Sussex
NHS Foundation Trust

Worthing Hospital
Trust HQ
Lyndhurst Road
Worthing
West Sussex
BN11 2DH
Tel: 01903 205111
www.uhsussex.nhs.uk

Our Ref: GF

3 March 2025

Mr J Turner
Area Coroner for West Sussex, Brighton and Hove

Dear Mr Turner

RE: Regulation 28: Report to Prevent Future Deaths: Mark SUMMERSETT

I write to formally acknowledge receipt of the Regulation 28 report to prevent future deaths and to respond to your matters of concern. Please be assured that the report has been considered by the Medicine Division Leadership and operational team (Worthing, St. Richards and Southlands), and also Trust wide across the four main UHSx hospital sites with the Medicine, Specialist, Surgical, and Cancer Divisions who manage all the wards and Emergency Departments (EDs).

Please find below the response to your concerns raised, which I hope will give the assurance required that the Trust has fully reviewed and communicated the current processes to be followed following absence of a patient to reduce the likelihood of a similar incident occurring again.

There was a lack of information sufficiency, flow and sharing across the agencies whilst he was present in, and at and after the point he left the ED, which might have enabled greater efforts to locate, contact and more urgently treat him.

Following the investigation report into Mr Summersett's attendance and suicide in February 2024, I would firstly confirm that the two key actions in the action plan (support for triage at times of high demand and handover from police to Trust staff) have been addressed.

Since this incident in February 2024, the Trust has undertaken a large amount of work in relation to its processes around missing persons from wards or EDs. This has also been as a response to the Right Care and Right Person National Programme (RCRP) and changes to the Police response to following up Welfare checks (Phase 1), and Missing Persons (phase 2), and also later phases (3 & 4) of reduction to conveyances and time spent in hospital with those under s136.

Over the past 12 months (January 24 – January 25) Worthing ED has had 199 patients recorded on their electronic system who have absconded from the department (range between 6 – 22 per month). Of these from the electronic records we are aware that 51% (102 patients) were referred for police follow up.

Prior to May 25th when the RCRP missing persons became live across Sussex, the referrals to police for follow up were between 50 – 75% per month and post Phase 2 go-live, the EDs have reduced the referrals to police, in line with the referral criteria for only critical concern/high-risk patients to be referred to between 40 – 50% (1 month only). Prior to the policy change the ED had referred patients to the police considered medium to high risk, and this has now changed to only those of critical concern/high risk. This risk is assessed on a case-by-case basis prior to referral and after liaison with Sussex Partnership NHS Foundation Trust (SPFT) as first line, to review any existing mental health history, prior to calling police. If there is any doubt in whether to refer or not to the police, they will refer, for police to decide whether they will follow up.

The Divisional Directors of Nursing for both medicine divisions, together with the Managing Director for Urgent/unplanned care, have attended the system wide meetings led by the Sussex ICB, to represent the Trust with system partners, SPFT, Police, Local authority (AMHP service) and East Sussex Health Care NHS Trust (ESHT). These commenced early 2024 and have continued throughout last year and into 2025, with working groups still ongoing for both missing persons and s136 phases.

The Trust has fully reviewed and revised the Missing Persons policy, with more information around the required processes in relation to patients who are at risk of absconding, and actions to be taken when patients do leave. This was done collaboratively across primarily the medical divisions and ED teams, but also with the other Divisions. There is detailed information around the legal principles and powers available to staff to detain and prevent patients from leaving (Mental Health Act and Mental Capacity Act) alongside more detailed information about the police response to missing persons, and criteria of those patients of critical concern who they will respond to. There are clear guidelines, flow charts and documentation to be used for the assessment of vulnerable patients, a process if concern are intending to leave and once have left. This includes the communication needed to patient, next of kin (NOK), and other system partners who may or may not be involved in the patient's care pathway or management plan, and police involvement if deemed at high risk. The new policy also highlights that any patient self-presenting to ED will be escalated directly by the receptionist to the triage or nurse in charge to ensure early review regarding risk and follow up.

The policy essential documentation and guidelines therein, were circulated to all wards and EDs before May 25th when phase 2 of RCRP was introduced across Sussex, and the main documents and flow charts to be used sent as separate, ready to hand information. These were further recirculated in Q2 (following slight update/ minor amendments to the policy early September, which included the system escalation responses) to ensure there was a renewed focus for clinical teams.

There was also trust wide communication to all staff as part of the Trust's "Theme of the Week" in December 2024, where targeted information is shared at daily safety huddles across all the clinical areas for a week. This included key points around managing patients who have absconded, who should be contacted, documentation and follow up via incident reporting.

The Divisions of Medicine have continued to work collaboratively with SPFT colleagues over the year reviewing ED documentation (reviewing assessments of both triage and Mental Health Liaison Team (MHLT), enhanced observation processes, and the communications between the EDs and the

MHLTs). There will be a further review and update to the documentation following a further meeting planned in early March 2025.

There has been ongoing discussion with Sussex Police since October with regard to the handover process of patients when conveyed to ED by the police (outside of s136 process), to ensure this is robust and any such patient is handed over directly to an ED nurse when booking in at reception, so they can be immediately reviewed and prioritised for triage assessment. The police have developed a handover form (draft copy can be sent if required). This has taken 3 months to finalise and take through police governance processes and is being taken for ratification by the police service on March 5th. Once this is able to be used this will greatly help with pre-hospital information about the vulnerable person and aid ongoing risk assessments and follow up, especially in a scenario should the patient leave before being seen by MHLT.

The RCRP missing persons working group is also working on a pan Sussex poster for ED waiting rooms to encourage patients not to leave without seeking advice from reception or ED personnel and also information for external help and support services. This is currently being reviewed by Experts by Experience (EbEs) and, once more feedback has been received by them, the poster will be designed and used in all EDs.

Further work being undertaken in the ICB wide missing persons group will be commencing with regard to how to proceed with a whole system policy 'Missing from Emergency Department'. Trust senior nursing staff will continue to work collaboratively in these groups to ensure these pieces of work are taken forward for UHSx.

Since May 2024, UHSx have worked further with Sussex Police to review missing patients who have been referred to police for follow up post absconding. Daily reports are sent to the hospital nurse directors, medicine divisional directors of nursing, and ED matrons/heads of nursing, in order to review the patients, to confirm if request for police follow up was appropriate in terms of risk of patient or not, and also to share any feedback and learning.

The Trust has commenced on the Royal Sussex County Hospital and Princess Royal Hospital sites a fortnightly meeting to discuss cases with senior nurse leads/ED, police, SPFT and security teams present. This is helping to inform learning and improve processes and communication between all system partners. Similar meetings will be set up for Worthing Hospital and St Richard's Hospital sites to facilitate the same shared learning and improvements in processes. It is hoped these can commence in March 2025.

Post coroner's inquest, the Divisional Director of Nursing for Medicine, Worthing, has further followed up with lead in SPFT for Worthing site, and having reviewed the guidelines produced for MHLT colleagues, has developed some similar bullet point guidelines for wards and EDs for quick easy reference, and is recirculating these across the Trust with the key flowcharts and missing person documentation from the policy. This will provide further quick reference laminated guidance at point of care to help staff at the time when faced by an absconding patient, to ensure correct processes are followed to promote the patient's safeguarding to reduce potential harm after leaving the department. This can be provided as evidence should HM Coroner request this.

The ED at Worthing has also commenced a ‘streaming’ model at the front door during the day, i.e a nurse situated within the reception area to help with capacity and redirection of some patients away from ED and into Urgent treatment centre or Same day emergency care services. As well as providing immediate brief assessment by a nurse at point of booking in, this will reduce numbers waiting to be seen by the ED team, and both of these improvements should assist with prompt risk assessment of MH patients self-presenting, and also the time to first triage and MH risk assessment. Both issues for ED in this sad case.

I hope the above information provides HM Coroner with the assurance that UHSx has learnt from this extremely sad incident, and that there are processes in place and embedded across our EDs and wards with the aim to reduce the likelihood of such harm happening in the future. We will continue to work collaboratively with ongoing improvements with colleagues in SPFT and the Police in order to improve the pathway of care for these patients.

Yours sincerely

Chief Executive