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:** **Chief Executive of Sussex Partnership Foundation Trust**
1	**CORONER** I am Gareth Jones HM Assistant Coroner for the coroner area of West Sussex and 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 17 October 2023 I commenced an investigation into the death of Harry Benjamin SOUTHERN aged 19. The investigation concluded at the end of the inquest on 01 November 2024. The conclusion of the inquest was that: Harry Southern died on the 12th of October 2023 at Royal Sussex County Hospital in Brighton. He tied a ligature around his neck the day before which led to hypoxic brain injury. He did so with the intention of ending his life.
4	**CIRCUMSTANCES OF THE DEATH** Harry Southern had a history of mental illness and involvement from his GP, the Trust's mental health services and sessions with a private therapist. He had had a traumatic last year of his life which involved the death of relatives, the breakdown of a relationship and the suicide of someone he knew. He had had a previous suicide attempt in June 2023 and in October he left a final note and sadly took his life.
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) During the course of the Inquest, evidence was provided of the many services available to young men such as Harry who have attempted suicide including services such as the Haven and numbers they can contact if they are suicidal. However, I am concerned that this information is not in fact provided to people in Harry's circumstances. Evidence was heard from Harry's father that indicated that in fact the contact numbers are not answered and do not cater for those with hearing difficulties or other disabilities. Young people in particular are not aware of other services such as Papyrus, a charity that has a round the clock suicide prevention helpline aimed at young people who are suicidal. Younger people with mental health difficulties of course will tend to be more familiar with social media and apps to discuss their problems in addition to just conventional phone numbers. I am also alarmed at the evidence given at the Inquest that cutbacks and funding issues may result in services to those with mental health difficulties being reduced even further. The Health Secretary will be copied into this Report because I am concerned this may well be a national problem. The inability of young people in particular with mental health difficulties (and their families)

	to contact someone at all times who will be able to speak with them (or being made aware that there are agencies who can speak with them) does give rise to a risk of future deaths and action should be taken by the Trust to resolve this.
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 the 17th of March 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 Sussex Partnership Foundation Trust [redacted], GP at Carden Surgery in Brighton [redacted] (all family members) 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. I will send a copy to the Secretary of State for Health. 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: 23/01/2025** **Gareth JONES** **Assistant Coroner for** **West Sussex, Brighton and Hove**