Coroner Service
West Sussex, Brighton & Hove

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:** **The Chief Executive University Hospitals Sussex NHS Foundation Trust**
1	**CORONER** I am Joseph TURNER, Area 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 16 February 2024 I commenced an investigation into the death of Mark-Anthony SUMMERSETT aged 58. The investigation concluded at the end of the inquest on 09 January 2025. The conclusion of the inquest was that: On 5 February 2024 Mark-Anthony Summersett attended the Emergency Department at Worthing Hospital in the company of a Police Officer. Suicidal thoughts were reported and recorded by reception staff but Mr Summersett left around an hour later before being triaged or assessed for treatment. Over thirty six hours later he was sadly found deceased in his car in the Crown Car Park, Arundel on 7 February 2024, with self-inflicted wounds to his neck; Police ruled out any 3rd party involvement.
4	**CIRCUMSTANCES OF THE DEATH** Mr Summersett was known to local Mental Health Services (ATS), although he had cancelled multiple appointments for a full clinical assessment. He approached Police on 5 February 2024, at the station in Littlehampton trying to hand himself in for fraud. He stated that he felt he should be punished and everyone would be better off if he was dead. He said a decline in his mental health had led to him self-harming a number of times, but he didn't think he could actually end his life and had thrown away a razor blade just before coming to the police. Officers took him to Worthing General Hospital Emergency Department to receive help. They helped him sign in at 1840 and he told reception that he was experiencing suicidal thoughts. Officers left him in the care of hospital staff. He was seen around an hour later appearing calm. He was not called for triage until 1946 but did not respond. ED staff notified the MHLT who confirmed he was known to their service. They were only told he was experiencing suicidal thoughts and made internal notification to his lead practitioner. Both teams attempted contact by telephone to Mr Summersett's mobile, to no avail. MHLT were unaware that he had been brought to hospital by Police, who were not informed he had left the ED. Nor were his former partner or GP informed. Neither Police nor his partner therefore attempted contact. On 7th February Police and SECAMB were called at 1415 to report that a male had been found deceased in his car in Arundel, subsequently identified as Mr Summersett.
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:

	Whilst I heard evidence that the UHS Foundation Trust has a Missing Person policy – Walkouts/absconding patients (approved 23 May 2024), in Mr Summersett's case there was a lack of recorded and/or shared information across all the agencies and teams with whom he had had contact, or to whom he was known, such that an accurate and fully reflective risk assessment was not achieved, exacerbated by delays in the triage process in the ED. Mr Summersett was not notified to Police as a missing person and nor were Police informed he had left the ED, despite them simultaneously raising a safeguarding risk via a Vulnerable Adult Single Combined Assessment of Risk Form. In sum, there was therefore 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.
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 March 06, 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. You may wish to invite other agencies to contribute to any response. 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] (former partner) Sussex Police Sussex Partnership Foundation Trust 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: 10/01/2025 Joseph Turner Joseph TURNER Area Coroner for West Sussex, Brighton and Hove