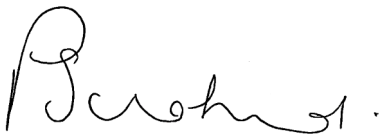
Coroner Service
West Sussex, Brighton & Hove

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:** **1 NHS England & NHS Improvement (reg 28 reports)** **2 NHS Sussex Integrated Care Board**
1	**CORONER** I am Penelope SCHOFIELD, Senior 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 13 November 2023 I commenced an investigation into the death of Sapphire Kathleen BERNARD aged 24. The investigation concluded at the end of the inquest on 13 January 2025. The conclusion of the Jury was that: Sapphire died on 30th October 2023 at East Surrey Hospital as a result of asphyxiation by self-tied ligature occurring at Langley Green hospital on 24th October 2023. The Narrative Conclusion of the Jury was: "Misadventure. The death was contributed to by vulnerabilities within the risk assessment and observation requirements used to manage admissions into Langley Green hospital".
4	**CIRCUMSTANCES OF THE DEATH** Following a deterioration in her Mental Health Sapphire was taken to the Accident and Emergency Department at the Conquest Hospital by Police on 2nd October 2023. She had been detained under section 136 Mental Health Act 1983. Whilst at the Hospital she underwent a formal Mental Health Assessment following which she was detained under Section 3 Mental Health Act. Sapphire was then nursed in A&E for a further 19 days awaiting a psychiatric bed. During this time there was no suitable psychiatric bed available for Sapphire. She continued to be nursed under 2:1 observations during this period. During this time she continued to self ligature. On 24th October 2024 Sapphire was eventually found a bed at Langley Green Hosptial. Within hours of being admitted to Langley Green hosptial she self tied a ligature whilst being nursed on intermittent observations. She was taken to East Surrey hospital but sadly died a few days later on 30th October 2023. Her cause of death was:- 1 (a) Hypoxic Ischaemic Encephalopathy 1(b) Asphyxiation by ligature 2. Mental health disorders including emotional unstable personality disorder and autistic spectrum disorder

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) 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 a psychiatric beds. 2. In Sapphire's case a bed was not found for her within a 19-day period. 3. The unsuitability of the environment of A&E as a holding place for those in need of a mental health bed. 4. 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 5. This is a second recent Inquest that I have heard where a death occurred following a lengthy wait in A&E for a psychiatric bed. In both cases the patients were transgender and had a diagnosis of autistic spectrum disorder.
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 April 2nd 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 **The family of Sapphire Bernard.** **Sussex Partnership NHS Foundation Trust** **The Conquest hospital** **PureCare Care Services LTD** 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. She may send a copy of this report to any person who she 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: 05/02/2025

	 Penelope SCHOFIELD Senior Coroner for West Sussex, Brighton and Hove