Coroner Service
West Sussex, Brighton & Hove

# Regulation 28: REPORT TO PREVENT FUTURE DEATHS

| | |
|---|---|
| | **REGULATION 28 REPORT TO PREVENT DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. NHS England & NHS Improvement** |
| **1** | **CORONER**<br><br>I am Joanne ANDREWS, Area Coroner for the coroner area of West Sussex, 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 21 March 2022 I commenced an investigation into the death of Ellame FORD-DUNN aged 16. The investigation concluded at the end of the inquest on 02 February 2026. The narrative conclusion of the inquest by the jury was that:<br><br>It was inappropriate for Ellame to be detained on a paediatric ward from 28th February to 20th March 2022 and the risk assessments in place were inadequate and inconsistently applied.<br><br>One to one observation was required by the risk assessment and this was provided on the 20th March. Security was not provided on Bluefin ward and there were no means to prevent her absconsion which occurred during a toilet visit. Ellame left the ward by the main exit and was not pursued immediately. Security and Police were notified, but 59 minutes elapsed until she was found by the Police.<br><br>The instructions given to agency registered mental health nurses were inadequate, patient notes were held on multiple systems, with access not freely available to agency staff and inadequately transferred during handover.<br><br>University Hospital Sussex NHS Foundation Trust policy for missing patients was not designed for high-risk mental health patients and the procedure to be followed in the event of absconsion was unclear and not appropriately communicated.<br><br>Death was more than minimally contributed by:<br><br>1. Inadequate provision of Tier 4 beds for children with severe mental health difficulties in Sussex and nationally.<br>2. The decision to detain Ellame on an acute paediatric ward without the |

| | |
|---|---|
| | provision of security.<br>3. The inconsistency of nursing handovers and little guidance on how to plan or respond if risk escalated or if Ellame absconded.<br>4. Poor co-ordination, communication and accountability between multiple agencies providing care for Ellame. |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br><br>Ellame had previously been a mental health patient at Chalkhill Hospital and had been managed in the community from 18th January 2022 until her admission to Worthing Hospital on 28 February 2022. Ellame was sectioned under Section 3 of the Mental Health Act on 12 March 2022.<br><br>Following that assessment, it was dertermined that Ellame needed admission to a Tier 4 Adolescent Mental Health Bed. As no Tier 4 Paediatric Mental Health beds were available she was detained to Worthing Hospital, which is an acute hospital with a paediatric ward designed for acute paediatric physical medical care.<br><br>The ward on which Ellame was detained did not have any facility for the doors to be locked and could be exited by pressing a green door release button. Ellame was nursed on 1:1 observations by a Registered Mental Health Nurse who was supervising her to the toilet when she absconded. Ellame pressed the green button and exited the ward. She was not followed immediately beyond the exit from the Ward into the main corridor. Ellame died [redacted] following her absconding from the Ward.<br><br>Ellame remained on the Acute Paediatric Ward at Worthing Hospital until her death on 20 March 2022 as there remained no Tier 4 bed available to her in Enqland at that time. |
| **5** | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows:<br>(brief summary of matters of concern)<br><br>1. I heard that there are insufficient numbers of Tier 4 Paediatric Mental Health beds available for the children and young people who have been assessed as requiring this level of admission. I heard that the waiting time for a bed for those who are under the Kent and Sussex Child and Adolescent Mental Health Services (CAMHS) Inpatient Provider Collaborative is, on average, 8 days.<br><br>2. I heard from clinicians at University Hospitals Sussex NHS Foundation Trust |

| | |
|---|---|
| | that they continued to have on acute paediatric wards a number of children and young people who have no physical medical needs for which they requirement treatment in an acute hospital but do not have packages of care in the community in place or a Tier 4 Paediatric Mental Health bed available to be admitted to.<br><br>3. I heard that at Worthing Hospital the Acute Paediatric Ward has been altered since Ellame's death but due to fire regulations cannot be locked in the same way as a Tier 4 Paediatric Mental Health Unit would be and is not designed for the admission and treatment of children and young people with mental health concerns. I heard that the staff are not able to provide the mental health care that these patients are considered to require in their setting. |
| **6** | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe 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 1 April 2026. 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<br><br>**The family of Ellame Ford-Dunn**<br>**The Nurse who cared for Ellame on 20 March 2022**<br>**Sussex Partnership NHS Foundation Trust**<br>**Care Quality Commission**<br>**University Hospitals Sussex NHS Foundation Trust**<br>**NHS Sussex Integrated Care Board**<br>**West Sussex County Council**<br><br>**and to the Child Death Overview Panel.**<br><br>I have also sent a copy of the report to Kent and Sussex Child and Adolescent Mental Health Services (CAMHS) Inpatient Provider Collaborative who may find this of interest. |

| | |
|---|---|
| | 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>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. They may send a copy of this report to any person who they believe 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: 03/02/2026<br><br>[redacted]<br>Joanne ANDREWS<br>Area Coroner for<br>West Sussex, Brighton and Hove |