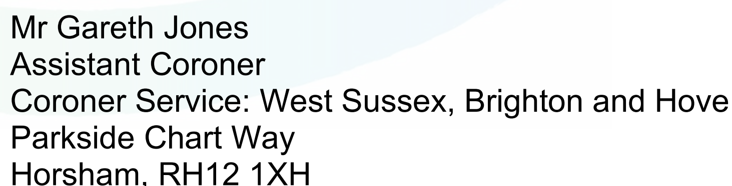
28 May 2026

Mr Gareth Jones
Assistant Coroner
Coroner Service: West Sussex, Brighton and Hove
Parkside Chart Way
Horsham, RH12 1XH



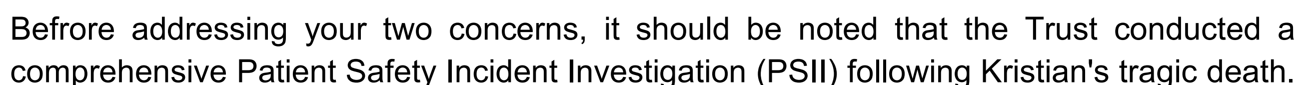
Dear Mr Jones

Thank you for your letter dated 26 May 2025 enclosing your Regulation 28 report following the conclusion of the Inquest into the death of Kristian Allen.

Firstly, I wish to extend my sincere condolences to Kristian's family and friends. I know that Kristian's Inquest has just concluded and lasted for two weeks, which I recognise must have been an extremely difficult experience for his Mother and Stepfather who I understand attended throughout. Yet, I hope that the thoroughness of your Investigation, together with this response enable them to have answers, as well as assurances as to the improvement actions taken since Kristian's death in February last year.

I understand that there are two areas which concern you, namely: authorisation of s17 leave and responsiveness to cardiac arrest. I also understand that you have already received documentary and heard oral evidence detailing the range of actions taken by the Trust, including the actions taken in relation to both areas of concern. Therefore, I recognise that you seek my further, specific assurance of those Trust actions and I am grateful to have the opportunity to write to you with this response and thereby provide you with that further assurance.

Befrore addressing your two concerns, it should be noted that the Trust conducted a comprehensive Patient Safety Incident Investigation (PSII) following Kristian's tragic death.



I am fully sighted on the findings of that PSII and was pleased to see that Kristian's Mother was collaboratively involved in it and that it candidly identified a full range of improvements. I note that the PSII specifically recognised that improved consistency in practice and application of standards was required in relation to both your areas of concern. In accordance with the PSIIs recommendations, the Trust implemented a coordinated programme of work which combines Trust-wide policy, training and governance improvements with targeted ward-level quality improvement. Notably, the PSII openly identified that Mill View Hospital needed to improve upon embedding learning from previous incidents through a positive culture of learning. I highlight this as I specifically note your reference, and therefore, understandable concern, about a previous death, which I understand was in May 2024, on the same ward. I also highlight because I recognise that the embedding of improvements within the complexities of mental healthcare services is multi-faceted in nature, takes time and committed, consistent re-enforcement. This is why, following Kristian's death, as a recommendation in the PSII we introduced the ongoing executive led improvement plan that you heard about at the Inquest and I will further explain to you once I have specifically addressed your two concerns.

Authorisation of s17 leave

As you heard during the Inquest, the conditions of s.17 leave are documented in a patient's electronic clinical record on the specific s.17 leave form and I understand that that was done for Kristian. However, I know that the nursing staff did not comply with the conditions despite them being clearly on Kristian's electronic record. This non-compliance was highlighted within the Trust's PSII report. I confirm, as you heard in evidence, that the Trust has already taken action to address this. Specifically, nursing staff's understanding of s.17 leave and the requirement to comply with conditions is tested though the use of competency tests. I am informed that [redacted] (Clinical Director) gave evidence at the Inquest to explain that a staff member's competency is re-tested until they can satisfactorily show their depth of understanding. Additionally, compliance is now consistently monitored via matrons, ward managers and governance processes to ensure high quality s.17 leave understanding is maintained. Furthermore, as you heard, the Trust has a programme of audits which specifically include checking legal compliance with s.17 leave conditions. The audits give rise to actions which are then overseen. Also, at ward-level re-enforcement of expected standards is now done routinely through team meetings, safety discussions and MDT processes. Further, as you heard from [redacted], bespoke training is being provided to staff on s.17 leave and, notably, the outcome from Kristian's Inquest will be specifically included in that training session which is schedule for next week. The combination of all of the above provides me with confidence that s.17 leave compliance is now not only being adequately monitored but any concerns in relation to inconsistent practices are being consistently recognised and addressed to ensure the expected standards are, and will continue to be, consistently applied.

Response to cardiac arrest

I appreciate your concern in relation to staff not being properly able to deal with cardiac arrests. You will have heard how this was recognised within the Trust's PSII and the need to strengthen preparedness and response to medical emergencies, including opioid overdose, resulted in recommended action. The identified action was the need to increase staff confidence in administering Immediate Life Support (ILS). I am informed that the Inquest heard of the impact upon staff of conducting ILS and how their confidence can be impacted by the rarity of having to conduct ILS. I confirm, as you heard, that as a direct action from the PSII into Kristian's death the Trust introduced regular simulation training ie: unannounced emergency simulations to which staff then have to respond. It is recognised that simulation training enables staff to develop their confidence beyond the basic level of skills and confidence achieved via the already existing mandatory ILS training. Additionally, as you heard, the Trust has now introduced new Automated External Defibrillators (AEDs) to support staff. These new AEDs give real-time information to the staff conducting CPR to inform them as to whether their rate and depth of CPR application is appropriate, thereby supporting staff to deliver high-quality CPR in line with guidelines. These new AEDs are also used in training to enable the resus team to see if those they are training are conducting CPR as optimally as possible. As you also heard in evidence the Trust's Resus policy has been updated to formalise the inclusion of simulation as standard in both clinical and non-clinical areas to enhance and embed medical emergency and cardiac arrest training, thereby ensuring staff remain competent and confident with emergency processes and procedures. The policy stipulates that simulations will be completed monthly throughout SPFT in inpatient hospitals. As [redacted] informed you, the most recent simulation on Kristian's ward took place on 20th May, involving 8 staff and simulated a scenario of an opioid overdose leading to cardiac arrest. I am informed that feedback from the ILS team was that the ward-team's response was well led.

Oversight of improvements

As I referenced above, the Trust's PSII openly recognised that embedding of a learning culture, specifically around areas of quality, was required at Mill View Hospital. Further, the PSII candidly recognised that the improvements identified following Kristian's death would require ongoing monitoring and executive oversight to support the necessary embedding of learning. I confirm that the Trust's Chief Nursing Officer has executive oversight of the PSII's actions. The Trust has had a recent change in its Chief Nursing Officer, with the new, permanent Chief Nursing Officer starting eight weeks ago. She has taken over as executive lead and will have ongoing oversight of the improvement plan, including a monthly oversight meeting at Mill View Hospital. I can also confirm that the improvement plan for Kristian's ward is aligned with the Royal College of Psychiatrists’ Culture of Care programme. This Culture of Care programme provides a framework for improving the quality, safety and

therapeutic environment of inpatient care through cultural and behavioural change, supported by:

- structured review of ward practice with staff and patients
- use of patient and staff feedback to identify priorities
- testing and embedding changes using quality improvement methods

Through this programme, Kristian's ward has implemented changes to:

- increase access to therapeutic activity and structured daily routines
- improve the physical and sensory environment
- strengthen patient involvement and community meetings
- improve communication and consistency of care delivery

Additionally, Mill View Hospital, as a whole, have been subject to external review by recognised specialist consultants in organisational performance and service improvement. Their work has focused on strengthening ward-level processes and operational consistency, including clarifying roles and responsibilities, improving documentation standards, and ensuring that actions agreed in MDTs and reviews are clearly recorded, owned and followed through. This has supported the development of a structured ward-level improvement plan, enabling learning, including from PSIIs, to be translated into consistent day-to-day practice and more reliable delivery of care processes.

In conjunction with the above, to ensure learning is embedded and sustained, at a divisional level, Brighton and Hove, has strengthened its governance and oversight, to ensure that learning from incidents is systematically reviewed, shared and translated into changes in practice, it now has:

- a new fortnightly Quality Matters meeting, providing structured review of safety, quality and improvement actions
- fortnightly Patient Safety Learning Bulletins, setting clear expectations for clinical practice across services
- routine discussion of learning within team meetings, supervision, MDTs and safety huddles
- Newly appointed Head of Nursing and Quality for Acute & Urgent Care services in Brighton and Hove
- Newly established substantive consultant psychiatrist on Kristian's ward

In summary, given the comprehensive range of actions already taken by the Trust there are no further new actions that I consider the Trust needs to take. That said, as I recognised above, all improvement requires sustained, committed focus. So, whilst I can already say that the actions described above are now embedded within policy, training, governance and ward-level quality improvement processes, which are subject to ongoing monitoring to ensure improvements continue, I would like to assure you that the oversight and focus on

these improvements will remain sharply in the Trust's focus to ensure sustained quality care is provided to our patients.

Thank you for raising your important concerns. I hope that the content of this response provides you and Kristian's family with assurance that meaningful action has already been taken, however, if I can be of any further assistance to you, please do not hesitate to contact me.

Yours sincerely

Chief Executive