REGULATION 29 RESPONSE TO A REPORT ON ACTION TO PREVENT FUTURE DEATHS

THIS RESPONSE IS BEING SENT TO:

The Senior Coroner, for the Coroner Area West Sussex, Brighton and Hove in response to a '**REPORT TO PREVENT FUTURE DEATH REGULATION 28**' following an investigation into the death of **Amy Clare CHAPMAN**, and an inquest that concluded on **24 April 2026**.

1.	**RESPONDENT** In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, **Sussex Partnership NHS Foundation Trust** provides this response within 56 days of the date of the Report to Prevent Future Deaths or any extension granted.
2.	**DATE OF RESPONSE** 19 June 2026
3.	**CONFIRMATION OF CORONER'S MATTERS OF CONCERN** The **MATTERS OF CONCERN** identified in the report are as follows: My narrative conclusion above, which includes a neglect rider, shows what I consider to have been a very serious failure. I have, very helpfully, had a number of commitments to review matters and/or review them further (some reviewing having already taken place), but I consider that the threshold for making a PFD report is reached (which makes a report mandatory), and in any event, the matters revealed by this inquest are such that a formal report should be made. This is because PFD reports are published, and improvements can then properly be tracked if appropriate. The matters of concern are as follows: 1. Insufficient focus at the Brighton Haven on whether and how trips out should take place. I am concerned, bearing in mind evidence on record-checking and keeping, that too much informality has crept in. 2. This may have been informed by there being insufficient focus in the policy, including in the policy as amended in October 2025. 3. Nurses not reading notes before taking significant decisions is a very serious concern, as is not then completing records of the decisions taken. 4. I am concerned about the variation in practice on the timing of notes. 5. I am concerned about what seems to be a lack of certainty concerning when formal safety plans (and/or care plans) should be completed. An informal one on admission followed by a full one after 24 hours seems reasonable, but the process and expectations ought to be clarified. 6. The lack of family involvement in risk management and planning is a

	breach of policy and would have been straightforward in this case. 7. There seems to be a lack of training for nurses moving from different settings to the Haven. 8. I am concerned as to whether there is now a facility in the case notes (now SystmOne) for there to be alerts around restrictions on trips out. 9. There has been a commitment to look again at this, but there is currently no written checklist for nurses to use when authorising trips out. 10. There has been a commitment to look at this too, but whilst care plans are the subject of audits, there is no auditing of the observations document against case notes, checking that trips out were properly risk assessed and authorised.
4.	**DETAILS OF ACTION TAKEN: How has the concern been addressed?** [If no action is proposed, please explain why here. If you feel that the response should not have been sent to you, please state this]. *Any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.* The Brighton Haven has taken the action, agreed at the Inquest, to introduce a new procedure for staff to follow when risk assessing patients prior to them taking time off the Haven. The new procedure has introduced an adaptation of the in-patient form, provided at Inquest, so that it is appropriate for use at the Haven. The new Haven 'Record of Time Away and Return' form is now completed by Haven staff as part of a focused, proactive, therapeutic conversation about the patient's time away from the Haven. As the Haven is a voluntary, community service, patients are not detained at the Haven and do not require permission to leave. Yet, the Trust wholly recognises that, in the interests of patient safety, it is essential to be vigilant about a patient's plans and whereabouts when away from the Haven, and careful, structured, collaborative consideration is needed. Therefore, the new 'Record of Time Away and Return' form is now used and records the clinical decision-making and risk management of the patient prior to them leaving the Haven. The new 'Record of Time Away and Return' form is completed as part of a collaborative, therapeutic conversation with the patient and specifically covers the parameters of the patient's time off the Haven, focusing on their safety. The '5Cs' approach is utilised. This 5Cs approach mirrors the approach that is also in use, with good effect, at one of the Trust's inpatient hospitals, and is currently in the process of being further evaluated for Trust-wide introduction. The 5Cs approach involves assessing the safety and potential risks of the patient taking time away from Haven in a way that is supportive and containing for both the patient and staff, with focused consideration being given to the following:

	Circumstances - Where are they going and what do they plan to do? When did they leave, and when are they planning to return? **Clothing** - What are they wearing? **Current Mental State** - How have they been over the last 24 hours? What impact has any PRN or regular medication had on this? Have there been any difficult conversations/acts of self-harm? Do they have capacity? **Consideration of Risk** - What are the current risks? Have they been out before, and how did it go? Do they have any thoughts of suicide/self-harm/harm to others right now? What will they do if they feel unsafe while out? **Contingency** - Ensure we have a correct phone number for them and anyone accompanying them. How will they access support if they feel unsafe while out? If they do not return, where are they likely to go, and who can we contact to inform them/ask if they have been seen? Complete appropriate Missing Persons processes as per SPFT policy. Once a patient returns to the Haven the new 'Record of Time Away and Return' form is updated and, if Haven staff have any concerns arising from the patient's time off the Haven, e.g.: if the patient's presentation is altered or there are concerns regarding contraband items, these concerns are escalated to the Nurse-in-Charge and consideration is given to whether any further actions or plans to manage any associated risk are needed. The new Haven 'Record of Time Away and Return' form is now part of the Haven's clinical records audit programme, to ensure it is being correctly used and that staff can be further supported and trained in the new process, if needed. Specific, focused action has also been taken in relation to the individual practice concerns identified at Inquest to support and improve the Haven nurses' practice. Regarding the variation in practice on the timing of notes, the Trust has recognised that there was no specific standard in place at the Brighton Haven, so action has been taken to develop a specific standard to ensure accurate timings of interventions are consistently recorded. Action has also been taken to ensure there is certainty about when a formal care and safety plan should be completed. The Haven Operational Policy has been updated (to be ratified imminently) to include the following specificity: *Whilst a formal care plan recorded on the Trust clinical information system care planning tab is not required until a person has remained in the Haven beyond 23 hours, it is recognised that care planning is an ongoing process which begins from the point of admission to the Haven.* *From admission onwards, there will be continuous consideration and discussion of the person's care needs, risks, safety and required interventions and support.*

	This evolving clinical understanding will inform decision-making throughout the patient's stay. *Prior to the requirement to complete a formal care plan (for episodes exceeding 23 hours), this ongoing process of care planning must be clearly recorded as clinical entries within the person's record.* *This ensures that care is actively planned and responsive from the outset, visible and auditable prior to any extended length of stay, aligned with the overarching principles of collaborative, dynamic risk formulation and crisis assessment within the Haven model.* A number of actions have also been taken to improve family involvement, including, as part of a specific Brighton Haven Team training day, reaffirming the principles of the Triangle of Care and conducting carer involvement simulation sessions to improve practice. Triangle of Care is a nationally recognised, collaborative framework that involves the patient, their carer, and professionals working together to support recovery, safety, and wellbeing. Adherence to the framework will be monitored. Action has also been taken to review and ensure the Haven induction process is robust and that Supervision of staff is consistently in place to address any support needs of new staff. Regarding the Coroner's suggestion that an alert be placed on the Electronic Patient Record system, around restrictions on trips out, the action taken, as described above, has been to include leave risks within the new 'Record of Time Away and Return' procedure and, additionally, notable leave risks are now also included on the Haven's handover document.
5.	**DETAILS OF FURTHER ACTION PROPOSED** *Any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.* All the above actions will be subject to ongoing monitoring, including focused auditing, to identify any further improvement actions that might be needed. Further improvement actions will then then be taken, as required.
6.	**SIGNATURE**  **Chief Executive Officer** **Sussex Partnership NHS Foundation Trust**