Coroner Service
West Sussex, Brighton & Hove

# Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

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| | **REGULATION 28 REPORT TO PREVENT DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1 Sussex Partnership NHS Foundation Trust** |
| **1** | **CORONER**<br><br>I am Nick ARMSTRONG, Assistant 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 28 March 2025 I commenced an investigation into the death of Amy Clare CHAPMAN aged 36. The investigation concluded at the end of the inquest on 24 April 2026. The conclusion of the inquest was that:<br><br>Amy Clare Chapman died on 27 March 2025 having jumped from a bridge [redacted] She was suffering a mental health crisis and it has not been possible to ascertain whether she was capable of forming the intention to die. |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br><br>In March 2025 Amy Clare Chapman was suffering declining mental health. Following a brief period of treatment in the community she was admitted to the Haven Unit at Millview Hospital in Brighton on 23 March 2025. That is an informal community based placement to which Amy had consented but proper risk assessment and management is still required, particularly where, as here, someone is assessed as representing a high risk of suicide. Amy did not receive a proper care plan throughout her time at the Haven and in particular there was no proper focus or planning as to when and how she might be permitted to leave the unit. Amy had not been out before 27 March. On that day, however, she was permitted to leave twice and by two different nurses. Neither nurse knew Amy well. Yet neither checked her case records before agreeing that she could go. Neither contacted the family despite the notes suggesting Amy should only go out with family. Neither nurse recorded their decision or the reasons for it in Amy's notes. In the circumstances of this case, that was a gross failure of basic care and amounted to neglect. Amy remained out for four hours. Towards the end of that period she diverted family members and in particular her partner by saying, over the telephone, that she was elsewhere. Just before 5 pm she jumped from a bridge [redacted]. Amy died of her injuries later that evening in the Royal Sussex County Hospital. |
| **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>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 |

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| | report should be made. This is because PFD reports are published and improvements can then properly be tracked if appropriate.<br><br>The matters of concern are as follows:<br><br>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.<br><br>2. This may have been informed by there being insufficient focus in the policy, including in the policy as amended in October 2025.<br><br>3. Nurses not reading notes before taking significant decisions is a very serious concern, as is not then completing records of the decisions taken.<br><br>4. I am concerned about the variation in practice on the timing of notes.<br><br>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.<br><br>6. The lack of family involvement in risk management and planning is a breach of policy, and would have been straightforward in this case.<br><br>7. There seems to be a lack of training for nurses moving from different settings to the Haven.<br><br>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.<br><br>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.<br><br>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. |
| **6** | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by June 20, 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>[redacted] **- Father**<br>[redacted] **– Slater and Gordon**<br>[redacted] **– Sussex Partnership NHS Foundation Trust** |

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| | 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: 27/04/2026<br><br>[redacted]<br>Nick ARMSTRONG KC<br>Assistant Coroner for<br>West Sussex, Brighton and Hove |