	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
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1	**CORONER** I am Mrs Louise Hunt HM Senior Coroner for Birmingham and Solihull
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 9 October 2020 I commenced an investigation into the death of Matthew Alexander CASEBY. The investigation concluded at the end of the inquest. The conclusion of the inquest was; Matthew Caseby became acutely unwell with a psychotic illness on 03/09/20. Following his admission and subsequent absconsion from the Priory Hospital in Edgbaston, Matthew stepped in front of a train on 08/09/20 and was fatally injured. At the time, Matthew was suffering from disorder thinking and did not have the capacity to form any intention to end his life. Matthew absconded from Beech ward on 07/09/20. He absconded over a fence in the courtyard area and at the time of his absconsion Matthew was unattended. It was inappropriate for Matthew to be left unattended in the courtyard. There were concerns regarding Matthew absconding but the recording processes on Beech ward were inadequate which resulted in the communication to staff involved in Matthew's care being lacking. As a result of risks not being fully recorded, Matthew's risk assessment was not adequate as it was not based on all of the available information. There were shortcomings in the Priory processes for recording and sharing information between staff. Matthew was not on any specific observations in the courtyard to avoid his risk of absconsion. There was no written policy on observation levels in the courtyard, the omission of which led to a lack of consistent understanding by staff as to what should happen in the area. This made the courtyard area unsuitable for use by patients. The Priory staff did have concerns regarding the height of the fence in the courtyard at a ward level but there is no evidence that there was a formal raising or escalation of this issue to a senior level which was a missed opportunity. However senior hospital management were aware of previous absconsions over the courtyard fence. When reviewing these incidents there was insufficient attention paid to the physical security of the area, with the focus being on the reasons why the patient absconded rather than how they absconded. This was a missed opportunity. Overall, the inadequate risk assessment for Matthew, the inadequate documentation records, the lack of a risk assessment for the courtyard area and the absence of a policy regarding observations levels in the courtyard means that the courtyard was not safe for Matthew to use unattended. His death was contributed to by neglect on the part of the treating hospital.
4	**CIRCUMSTANCES OF THE DEATH** Following calls to the Police from members of the public reporting sightings of a male on the railway lines and in a school playground, Matthew Caseby was found by Oxfordshire Police in a playground in Islip in Oxfordshire on 03/09/20. Following a conversation with Matthew, the Police officers took the decision to detain him under Section 136 of the Mental Health Act.

Matthew was taken to a place of safety at Vaughan ward part of Warneford Hospital, where he was assessed and detained under Section 2 of the Mental Health Act as he was found to be suffering from a mental disorder of a nature or degree which required detention for his or other's safety.

Due to his registered GP being in Birmingham, because of him previously being a student at Birmingham University, a bed was found for Matthew at the Priory Hospital in Edgbaston, Birmingham.

Matthew arrived at the Priory Hospital at 05:05 on 05/09/20. At 06:00 on 05/09/20 Matthew was assessed by the resident medical officer (RMO). The RMO completed a risk assessment in the presence of a registered nurse and a healthcare assistant. The RMO recorded that Matthew had a low suicide and self harm risk and recorded an overall medium risk on the risk assessment. The RMO determined that level 2 observations be put in place meaning that he would receive 4 checks per hour.

Notes recorded by staff on 05/09/20 show that Matthew presented as guarded and delusional and that he wanted to leave the ward. Matthew was also seen to be responding to unseen stimuli.

Evidence presented show that on 06/09/20 Matthew was presenting as guarded, anxious and responding to unseen stimuli. It was also recorded on the handover notes that Matthew was at risk of absconsion. It was noted that Matthew was loitering by ward exits and that he made an attempt to leave with a black bin bag.

Although it was not recorded in any of the written notes a HCA gave evidence that on 06/09/20 Matthew was observed looking at the fence in the courtyard and that she was concerned that he would try to abscond. To mitigate this the HCA gave evidence that she stood at the highest point of the steps. The HCA advised that she made a colleague aware verbally but did not record this risk in any of the written notes.

The handwritten handover notes do mention that Matthew was at risk of absconsion but the notes were incomplete. The information regarding Matthew's risk of absconsion was not captured on the electronic notes which were the ones relied upon by the doctors when completing the ward round/MDT.

The ward round/MDT took place and Matthew was seen by 2 doctors and 1 registered nurse at 13:30 on 07/09/20. One of the doctors reviewed the electronic notes. The handwritten notes were not present during the MDT and the contributing nurse gave evidence that she did not read these in advance as it had been a very busy shift and she did not have time. The risk assessment (initially completed by the RMO on 05/09/20) was not reviewed during the MDT. Matthew reported low mood during the MDT. The senior doctor prescribed anti-psychotic medication, but Matthew refused to take this.

Following the MDT the nurse raised concerns to the doctors that Matthew was physically fit and would be able to scale the fence in the courtyard should he try to. Upon hearing the concerns no additional risk assessment was undertaken and no additional measures were put in place. Both of the doctors gave evidence that they assumed Matthew would be supervised at all times in one courtyard as was standard practice (although there was no official policy).

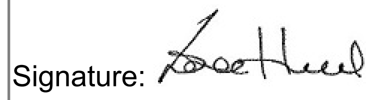
On 07/09/20 at 16:40 Matthew asked a HCA if he could go into the courtyard and was escorted out by the HCA who remained with him initially. After 15 minutes the HCA asked Matthew to return inside but he refused. The HCA left Matthew in the courtyard under the supervision of 2 other HCAs who were supervising two other patients who were on 1:1 checks. Matthew was observed throwing something over the courtyard perimeter fence. At 17:02 one of the HCAs returned inside to flag that her and her colleague would be returning inside with their 121 patients meaning that Matthew would be left unattended in the courtyard. This was flagged to the nurse in charge and the original HCA.

Matthew was inappropriately unattended in the courtyard. This was in contrast to what the majority of staff reported to be standard practice during their evidence. There was no official written policy

	or guidance on supervision or observation in the courtyard and there was no risk assessment in place. Matthew was unattended for 1 minute and 40 seconds initially. During this time the HCA who had originally given him access to the courtyard could be observed on CCTV images in the nurse's office and using the staff toilet. The HCA then approached the courtyard and viewed Matthew through the vestibule window. Before the HCA could rejoin Matthew in the courtyard, she was called by a colleague to assist with an emergency ligature situation. This meant that Matthew was unattended for a further 5 minutes. No staff member was informed he was unattended. CCTV showed Matthew moving towards the courtyard fence at 17:06 and he then disappeared from the view of the camera. At 17:07 a HCA on her break in the smoking area observed Matthew walking past her. She approached Matthew and asked if he was OK but he did not respond. The HCA made her way to Beech ward to inform staff of what she had seen. Another HCA was on her break and stood at the bottom of the hospital driveway. She saw and recognised Matthew and asked him where he was going. Matthew responded that he was "going home" and picked up speed as he left hospital grounds. The HCA called Beech ward to report what she had seen. The nurse in charge of the ward immediately called 999 upon realisation that Matthew had absconded. No other action was taken by the staff at the Priory. Although staff did have concerns regarding the height of the fence in the courtyard, there is no evidence that it had been raised in any written or official way or followed up, through established forums to make senior hospital management aware. Although the height of the fence did meet national guidelines the courtyard was not suitable for patients to use due to the lack of a risk assessment and the absence of any written policy specifying observations and supervision whilst the patients were using it. At 17:56 on 07/09/20 Police arrived at the Priory Hospital having already searched the local area in an attempt to find Matthew. On arrival at the ward, the officers spoke to the staff present in the nurse's office. The Police attempted to get additional information that could assist them with finding Matthew such as next of kin, previous addresses or known contacts. The Priory staff advised Police that Matthew was very guarded and that they didn't have this information. Police were provided with Matthew's section paperwork from the hospital in Oxfordshire. When reviewing this paperwork once they'd left the Priory, the Police saw that Matthew had been found on railway lines, which was information that they had not previously been aware of. At 18:46 the Police made British Transport Police (BTP) aware of Matthew as a missing person. There was some confusion around where Matthew was originally picked up by the Police in Islip. Inconsistencies in paperwork showed that Matthew was found on railway lines, but it was a children's playground where he was picked up. At 19:20 West Midlands Police (WMP) opened a missing person record for Matthew and recorded that he was a medium risk. At 19:32 [redacted], Matthew's Father, contacted Police to raise concerns that Matthew may try to harm himself. Matthew's risk level remained at medium. The Police gave evidence that they were in contact with Matthew's Mother and Sister over the course of the evening. Based on information received from them a previous address and place of employment were attended. They also searched the Selly Oak triangle area of Birmingham which Matthew was familiar with, in an attempt to find him but unfortunately Matthew could not be located. At 01:27 on 08/09/20 Matthew's case was assessed again by the Police response manager and found to be medium risk. No further search took place and the case was handed to the locate team.

	The locate team picked up Matthew's case at 07:00 on 08/09/20. At this point the risk level was raised to high. Officers were allocated to try to find Matthew and a fast track action list was set out. Officers were limited with what checks they could complete due to the fact that Matthew didn't have a debit card or mobile phone and had no contacts in the area. Evidence from British Transport Police confirmed that a collision occurred between a train and a male at 08:40 on 08/09/20. The train had departed University Station and was travelling in the direction towards Five Ways Station. The train was accelerating and was within the permitted speed limits. As the train was adjacent to Vale Campus location the driver saw Matthew appear from undergrowth. Matthew ran out and placed himself in front of the train. As soon as the driver saw Matthew, he applied the emergency brake and sounded the horn. Unfortunately, the driver was unable to stop in time and the collision took place. It was confirmed that the collision was fatal at 09:11 by the Paramedic at the scene who confirmed life extinct. It was established that Matthew was the individual who had been hit by reviewing CCTV images of Matthew. Formal identification took place using fingerprints. Between Matthew absconding from the Priory over the courtyard fence at 17:06 on 07/09/20 and the collision that took place at 08:40 on 08/09/20 there is no evidence showing Matthew's whereabouts or activities. Following a post mortem the medical cause of death was determined to be: **1a Head Injury** **1b High Impact Collision with a Train** **1c** **II Psychotic episode**
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: For the Priory Hospital 1. **Record keeping**: During the inquest staff confirmed that they record information about patients in two ways. On the electronic records and on handwritten handover sheets. During the inquest the evidence confirmed that different information was recorded on each. I have serious concerns that staff are recording information in two places and this creates a real risk, as materialised in Matthew's case, that different information is recorded in each place and key information gets lost. 2. **Record Keeping quality**: There were numerous inaccuracies in Matthew's medical records, eg his status was written as informal when he was formal, he was described as violent when he was not and was described as "she". Staff were unable to explain how that occurred. The investigation witness from the Priory thought there was an element of cutting and pasting into the records from another patient's records. I have serious concerns about the accuracy of the clinical record at the Priory for what are some of the most vulnerable patients. 3. **Risk Assessments**: The inquest heard how all members of staff can update a Risk Assessment at any time. Despite this, and with clear evidence that Matthew was at risk of absconsion, his risk assessment was not updated over the weekend when the risk materialised. I have serious concerns about how risk assessments are completed, when

	they are completed, who completes them and whether they are updated in a timely and necessary manner by suitably experienced staff. 4. **Serious Incidents**: The inquest heard evidence that a previous absonsion over the courtyard fence in October 2019 had not prompted any review of the height of the fence and focussed on why the patient absconded ie to have a cigarette. I have serious concerns that the system of investigation in place at the Priory means critical lessons are not learnt at the appropriate time. 5. **Courtyard Fence**: A patient absconded over the courtyard fence during the inquest which indicates the courtyard area is not safe. I have serious concerns that an urgent review of the courtyard is required. In addition, I heard evidence from Dr [redacted] that the fence was a ligature risk. Staff gave evidence that the courtyard in its current format with steps and a gradient on the grass bank was unsafe especially if a patient needed to be restrained. For the Department of Health 1. **National guidelines for perimeter fences and security in acute mental health unit outside areas.** The inquest heard evidence from Professor [redacted], a specialist in safety in Mental Health settings, that it would be useful for there to be standard guidelines for the requirements of perimeter fences and security for outside areas in acute Mental Health units as no such guidance is in place. This would ensure the correct level of security for some of the most vulnerable patients whilst maintaining a therapeutic setting.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 17 June 2022. 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: Mr Caseby's family The Priory Group West Midlands Police British Transport Police Birmingham and Solihull CCG Birmingham Women's and Children's NHS Foundation Trust I have also sent it to the Medical Examiner, NHS England, CQC, who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he 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	**22 April 2022** Signature:  **Mrs Louise Hunt** **HM Senior Coroner for Birmingham and Solihull**