REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: 1. Secretary of State for Health and Social Care, Department of Health and Social Care, 39 Victoria Street, London SW1H 0EU, in respect of Item One of the Matters of Concern; 2. [redacted], Chief Executive Officer, Priory, Floor 5 Hammersmith Road, London W14 8UD, in respect of Item Two of the Matters of Concern.
1	**CORONER** I am Andrew Bridgman, Assistant Coroner, for the Coroner area of South Manchester
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 15th October 2020 an investigation commenced into the death of James John Jude Booth who died on 14th October 2020. The inquest concluded on 26th May 2022. **The medical cause of death was:** 1a) Hanging **The conclusion of the jury was:** James Booth took his own life by hanging. James was found at 11.09am on the 14th October 2020 at [redacted] following his absconsion from the Priory, Altrincham on 7th October 2020, where he was being detained under Section 3 of the Mental Health Act. There was a delay in the police response time, however this not causative of his death. Factors that contributed are as follows: <u>Security of Tatton Ward</u> Inadequate security of the garden, including fence height and nearby ledges <u>Risk management</u> Failure to follow communication procedures and associated documentation highlighting essential handover information. Inadequate risk assessments. Possible contributing factors: Failure to implement adequate risk management procedures. Failure to increase observations based on patient's perception.
4	**CIRCUMSTANCES OF THE DEATH** At the time of his death James Booth was 52 years of age. James suffered with longstanding mental ill-health. In 2006 he was a detained patient for some 18 months, followed by rehabilitation in the community over 2-3 years to 2010. His chronic diagnosis was anxious avoidant personality disorder. Towards the end of June 2020, probably as a consequence of the restrictions imposed by Covid, James suffered a breakdown in his mental health. He was admitted (under Section 2 of the MHA) on 3rd July 2020 and discharged on 10th July 2020. On 18th July 2020 James made an unsuccessful attempt to hang himself. James was admitted to The

Priory, Altrincham. There were no local NHS acute beds available. The plan was for repatriation at the earliest opportunity. The diagnosis was anxious avoidant personality disorder, with severe depression and some symptoms of psychosis.
On 14th August 2020 James made an attempt to abscond. James made a number of references to his wish to escape and to end his life.
James was on Level 2 observations (2 per hour) from 30th July 2020

Period from 01.10.20 to James absconding on 07.10.20.

01.10.20:
James had to be persuaded to come back on to the ward on return from breakfast at the Grange (off Ward). This matter was noted on the Ward Round later that morning. A Risk Assessment was carried as per routine for the Ward Round.

04.10.20:
James made an attempt to push past a member of staff when they were coming through the main door to the Ward. This event was noted in the Care Notes with the note "wanted to run away and *commit suicide".* It was not recorded in the Datix system. The Responsible Clinician was not informed. No risk assessment was carried out. The event was recorded on the handover sheet from the 04.10 Dayshift (DS) to the 04.10 Nightshift (NS) within the Clinical Risk section. It was not noted in box 'Incidents in last 7 days'.
The event was not recorded in the Clinical Risk section of the 04.10 NS to the 05.10 DS. It was not noted in the box Incidents in last 7 days', and did not appear in that Box for any of the subsequent handovers.

05.10.20
At around breakfast time James was seen walking up the main drive of the hospital towards the main entrance. When James realised he had been seen he ran away out of the grounds but was eventually caught up with and brought back to the Ward. He would not say how he escaped from the Ward but from his position when first seen it was likely to have been from the garden area of the Ward. This event was noted in the Care Notes. It was recorded in the Datix system – but the report was closed with 'no lessons to be learned'. The Responsible Clinician was not informed. No risk assessment was carried out. The event was recorded on the handover sheet from the 05.10 DS to the 05.10 NS within the Clinical Risk section. It was not noted in box 'Incidents in last 7 days'.
The event was not recorded in the Clinical Risk section of the 05.10 NS to the 06 DS. It was not noted in the box Incidents in last 7 days', and did not appear in that Box for any of the subsequent handovers.

06.10.20
During an escorted walk within the hospital grounds James made attempts to divert the walk away from the planned route, one of them towards the adjoining golf club. When near to the main entrance James tried to run away but staff blocked his way.
This event was noted in the Care Notes.
It was not recorded in the Datix system. The Responsible Clinician was not informed. No risk assessment was carried out. The event was recorded on the handover sheet from the 06.10 DS to the 06.10 NS within the Clinical Risk section. It was not noted in box 'Incidents in last 7 days'.
The event was not recorded in the Clinical Risk section of the 06.10 NS to the 07.10 DS. It was not noted in the box Incidents in last 7 days'.

07.10.20
James absconded at around 13.15 to 13.30 hrs. He was last seen in the vicinity of the door leading out on the garden. The probable route of escape was over the garden fencing.

14.10.20
James' body was found as above.

5	**CORONER'S CONCERNS** 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. – **Matter One** The inquest heard that the Priory had identified that the garden fence was a risk, in particular the section over the door, in about December 2019. There had been a number of escapes both over the fence and through it, in the months leading up to James' escape. The number of escapes indicates that garden area was not safe. There was a plan to replace it but there were other priorities. More striking was that there is no national guidance for perimeter fencing and security for the outside areas of mental health 'locked wards'; unlike that in existence for mental health 'secure units'. In particular, the height of the fence. While it is accepted that national guidance ought not be necessary to carry out appropriate risk assessments and ensure secure/safe spaces it is clear that such guidance is necessary to ensure the correct level of security for vulnerable patients, whilst benefitting from the therapeutic setting of an outdoor space. **Matter Two** The evidence showed that there was no appreciation of the emerging pattern of behaviour. A major contributing factor was the lack of exchange and transfer of information at the handover between the consecutive shifts. In particular, the form specifically designed for this with a section for completion – 'Incidents in last 7 days' which would have provided an information flow through was not completed. Whilst I heard evidence of steps taken to improve information exchange at a higher level than between ward staff (nurses and HCAs) I was very surprised to hear that no audit of these 'handover documents' had been carried out. Given the fundamental importance of the exchange of information between each shift and consecutive shifts I am of the opinion that The Priory have not carried out a sufficiently robust review. Until this failure is addressed there is a significant risk of a breakdown in the communication of adverse events across the shift pattern of several days. The risk of a lack of appreciation of an emerging pattern of behaviour remains.
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 **11th September 2022**. 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 namely, Mr Booth's family, 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	**Dated this 17th July 2022**  **Andrew Bridgman** **HM Assistant Coroner**