IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of William SAVORY
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive Surrey and Borders Partnership NHS Foundation Trust Third Floor Leatherhead House Station Road Leatherhead Surrey KT22 7FG
2	**CORONER** Miss Anna Crawford, HM Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
4	**INQUEST** The inquest into the death of William Savory was opened on 5 March 2020. The inquest was resumed on 25 April 2022 and the conclusion was handed down on 29 April 2022. The medical cause of Mr Savory's death was: 1a. Acute Alcohol Toxicity The inquest concluded with the conclusion of 'Alcohol-Related Death'.

5	CIRCUMSTANCES OF THE DEATH Mr Savory was a 31 year old man who had been diagnosed with Mixed Personality Disorder. On 17 January 2020 he had been released from a term of imprisonment at HMP Highdown and was of no fixed abode. On 18 January 2020 he was admitted as an informal patient to the Abraham Cowley Unit (ACU), which is a psychiatric hospital run by Surrey and Borders NHS Foundation Trust (SABP). The purpose of his admission was to keep him in hospital for a week to observe and assess him, to trial him on an anti-psychotic medication, to support him to obtain housing and to refer him to Community Mental Health Team for support on discharge. On 26 January 2020 Mr Savory left the ACU to go into the grounds for a cigarette at 18:10 but he did not return at the agreed time of 18:35. On the morning of 27th January 2020 Mr Savory was found deceased in a shed which had been converted into a bar at his parent's home address. His death was due to acute fatal alcohol toxicity and was the unintended consequence of drinking a significant amount of alcohol including two bottles of [redacted]

6	**CORONER'S CONCERNS** The Coroner's concerns are set out below. The court heard evidence that Mr Savory did not return at the agreed time of 18:35 on 26 January 2020 and that staff were aware that he had not returned from 18:45 onwards. The court found that thereafter there was a delay of approximately two hours in instituting the missing persons protocol and reporting Mr Savory as missing to the police. During the course of the inquest the court heard evidence that the SABP Missing Person Protocol requires staff to commence the missing person procedures immediately if a patient, including an informal patient, does not return to the ward at the expected time. The court heard evidence from some members of staff who gave evidence that they were not aware of a particular timeframe for instigating the missing persons protocol in relation to informal patients, and as such I consider there is a risk of future delays in reporting informal patients as missing persons to police, which presents a risk of future deaths. The **MATTER OF CONCERN** is: SABP's written policies require staff to commence missing person procedures immediately, yet the Coroner is concerned that not all staff are aware of this requirement. The Coroner therefore invites SABP to consider additional training or other measures to raise awareness of this requirement amongst all levels of staff including Health Care Assistants.
7	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.

8	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
9	**COPIES** I have sent a copy of this report to the following: 1. Chief Coroner 2. Mr Savory's family
10	**Signed:** **Anna Crawford** **H.M. Assistant Coroner for Surrey** **Dated this 15th day of June 2022**