REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

(1) [redacted], Chief Executive, Birmingham and Solihull Mental Health NHS Foundation Trust ('BSMHFT')
(2) [redacted], Chief Constable, West Midlands Police ('WMP')
(3) Parties to the National Partnership Agreement: Right Care, Right Person:

a. Department for Health
b. Home Office
c. College of Policing: [redacted], Chief Executive Officer
d. NHS England: [redacted], Chair
e. National Police Chiefs' Council: [redacted], Chief Constable
f. Association of Police and Crime Commissioners: [redacted], Chief Executive

CORONER

1 I am James Bennett Area Coroner for Birmingham and Solihull.

CORONER'S LEGAL POWERS

2 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.

INVESTIGATION and INQUEST

3 On 05/10/23 I commenced an investigation into the death of Tcherno Bari. The investigation concluded at the end of the inquest on 21/05/24.

CIRCUMSTANCES OF THE DEATH

4 On 18/09/23 Mr Bari was sectioned under the Mental Health Act 1983 and admitted to a psychiatric unit at George Ward, Highcroft Hospital. He was diagnosed with psychotic depression.

Mr Bari's suicide risk factors included: (1) recent suicide attempts and ideation [redacted], (2) recent breakdown of relationship, (3) paranoid command delusions (being controlled by a chip in his head) and hallucinations (hearing two different voices making derogatory comments), (4) severe depression, and (5) cessation of anti-psychotic and anti-depressant medication (as recent as 24/09 and 25/09).

On 25/09/23 he violently (which was a further suicide risk factor in that it amounted to a change in behavior) forced his way through two secure doors and left the grounds. The Responsible Clinician (a senior Consultant Psychiatrist) prescribed an urgent intravenous tranquillizer, but nurses were not in a position to restrain Mr Bari. The Responsible Clinician was of the view Mr Bari was presenting with psychotic depression with florid command hallucinations and active paranoid delusions and considered him to be at high-risk of suicide. The police were called promptly and searched the local area for around 1 ½ hours. He was found deceased 23 hours later, on the next day 26/09, hanging from a tree in parkland outside the police search area.

The Nurse-in-Charge reported (relying only on her memory) some, but not all, of his suicidal risk factors during the 999 call. The call taker did not fully record this detail on the control log and the attending Constable was unaware. The Nurse-in-Charge (relying only on her memory) did not repeat this detail to the attending Constable and did not complete 'appendix C – risk rating' or hand it to the Constable (as required by the BSMHFT Missing Patient Policy) which would have amplified some, but not all, of his suicide risk factors. There was a conflict between the Nurse-in-Charge (an experienced

	and senior mental health nurse) and the police Constable (who was relatively inexperienced). The Nurse-in-Charge indicated Mr Bari was at high-risk of suicide. The Constable felt the Nurse-in-Charge could not rationalise the high-risk category, and decided Tcherno was at medium-risk of suicide (having in her view followed College of Policing: Missing Person Authorised Professional Practice). The medium-risk category was accepted by the Sergeant and Inspector, and later accepted by WMP's Locate team, taking the Constable's report about the facts at face value. The fact the police had taken a different view about the level of risk was not explained to George Ward, and neither the Nurse-in-Charge, Responsible Clinician, or Clinical Service Manager were aware. The Clinical Service Manager (as required by the BSMHFT Missing Patient Policy) did not 'immediately' (or at all) coordinate the attempts to locate the high-risk missing patient or invite a representative from WMP to a 'daily appraisal' meeting to discuss the information and circumstances. By the time Mr Bari was found deceased WMP had not requested BSMHFT's written risk assessment which would have amplified some, but not all, of his suicide risk factors.
5	**CORONER'S CONCERNS** During the inquest, the evidence revealed matters causing 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. My principal concern is that when a high-risk mental health patient is missing it requires effective and meaningful multi-agency co-ordination. Locally, it engages BSMHFT's Missing Patient Policy (which purports to append WMP's missing person procedures), national College of Policing: Missing Person Authorised Professional Practice ('APP'), and National Partnership Agreement: Right Care, Right Person ('RCRP'). The evidence revealed significant gaps in knowledge, co-ordination and application of these policies. Specifically: *(1)* I am not reassured BSMHFT staff are handing attending police officers 'appendix C – risk rating' as required by their missing person policy. I am not reassured WMP officers are aware they should be provided with 'appendix C – risk rating'. *Context: I did not accept the Nurse-in-Charge routinely used 'appendix C – risk rating', and police witnesses - including a Locate Sergeant, and the Head of Locate, a Detective Chief Inspector - indicated they had never seen 'appendix C – risk rating'.* (2) A 'monitoring tool' in the BMSHFT Missing Patient Policy requires routine monitoring to ensure nurses are completing 'appendix A' and 'appendix B', but not 'appendix C – risk rating'. *Context: I was told this is under review, however I was concerned this is still outstanding 9 months following the death.* *(3)* I am not reassured BSMHFT Clinical Service Managers ('CSMs') are (a) coordinating the attempts to locate high-risk missing patients, and (b) inviting a representative from WMP to attend 'daily appraisal' meetings to discuss the high-risk missing patient's absence as required by their missing patient policy. I am not reassured WMP officers are aware this is the CSM's role and of the expectation of being invited to a 'daily appraisal'. *Context: this process did not happen in Mr Bari's case, and the WMP's Head of Locate said she was not aware of the police ever being invited by a CSM to attend a 'daily appraisal'.* (4) I am not reassured the RCRP 'challenge' process has been effectively communicated to BSMHFT. *Context: I was told by WMP's Head of Locate there has been an agreed 'challenge' process to WMP's decision on risk category since February 2024, albeit BSMHFT have never used it. However, I heard from BSMHFT's Head of Acute Nursing that there was no such process. Further, she explained ongoing frustration bearing in mind BSMHFT's expertise, that WMP often do not accept BSMHFT's reported high-risk category, WMP often do not*

	communicate they have not accepted it with BSMHFT only finding out much later, and WMP often close missing patient investigations without informing BSMHFT. (5) The BSMHFT Missing Person Policy purports to append WMP's missing person process but makes no mention of RCRP. I am not reassured the BSMHFT Missing Person Policy is therefore accurate and up-to-date. (6) RCRP does not require WMP to formally indicate to BSMHFT (i.e. via a form) when the police have taken a different view about the risk category. BSMHFT will often be unaware of the different view taken by the police rendering the 'challenge' process redundant and reducing the chances of the police identifying they have overlooked key information. (7) The BSMHFT Missing Patient Policy and RCRP do not require BSMHFT to hand attending constables a copy of the risk assessment, or require attending constables, or later the Locate team, to request a copy of the risk assessment. In the event of a conflict about risk category, requiring attending constables to take early possession of the written risk assessment may lead to the police identifying they have overlooked key information and revisit their own risk category. *(8)* RCRP and APP do not require attending constables to have particular regard to the expertise of mental health clinicians and hesitate or be extra vigilant before rejecting their opinion on risk category. RCRP and APP appear to regard reports from mental health clinicians no differently to those from members of the public, and family and friends of the missing person. *Context: police witnesses agreed that BSMHFT clinicians were the experts on mental health diagnosis, including identifying those conditions that carry an increased risk of suicide, and assessing the risk of suicide generally. However, this case demonstrates how in the heat of the moment an (inexperienced) attending constable can overlook that expertise and quickly dismiss it.*
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. BSMHFT and WMP are responsible at a local level for their own missing person/patient policies and the local implementation of RCRP and APP. College of Policing is responsible for APP (and a party to the national RCRP agreement). The remaining recipients are all parties to the national RCPR agreement.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 29 July 2024. 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: (1) Mr Bari's family. 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	Signature:  James Bennett Area Coroner, Birmingham and Solihull 03/06/24