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

The Inquests Touching the Death of Simon Richard Tree
(Formerly Gary Charles Randall)
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: [redacted] SABP NHS Foundation Trust. (The Abraham Cowley Unit).
1	**CORONER** Simon Wickens, HM Assistant Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	**INVESTIGATION and INQUEST** The inquest into **Simon Tree**'s death was opened on the 21st February 2012 and was resumed on 19th January 2015. It was concluded on 23rd January 2015. The cause of death found was: 1a – Drowing. The conclusion was a narrative as follows: At the time of his death, Simon Tree was a voluntary patient at the Abraham Cowley Unit having originally been sectioned in January 2012 following an attempt at taking his own life. On the 16th February 2012 he was returned to the Unit by Surrey Police having been found by the River Thames in a state of intoxication, expressing a wish to take his own life. As a result he was a known suicide risk and the following morning, 17th February 2012, he was due to be re-assessed. However, on the

	morning of the 17th February, prior to that re-assessment a member of staff allowed Simon Tree to leave the ward unsupervised thereby giving him access to an area of the unit where there were known concerns about the security of an exit door. In consequence, Simon Tree managed to leave the unit and was found on the 18th February 2012 in the River Thames at Sunbury Island having drowned. It is unclear how he came to be in the river or what his intention was at the time.
4	**CIRCUMSTANCES OF THE DEATH** At or about 17.25 hours on the 18th February 2012 Mr Tree was found in the river Thames having drowned. He had left the Abraham Cowley Unit the day before having been given access to an area there were known security concerns
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed a matter that gave rise to a concern that circumstances creating a risk of other deaths will continue to exist in the future unless action is taken. The **MATTER OF CONCERN** is as follows. – During the Course of the Inquest evidence came to light that whilst the door that Simon Tree left the unit from was now secure, there are security issues with the new airlock system. The Court heard that the onus of releasing people from the unit is placed on ward staff, who operate the airlock system remotely from the ward. Patients have been able to 'tailgate' visitors leaving legitimately and the Court heard 4 people had managed to leave this way in the last 12 months. On one occasion the camera in the airlock was simply moved to create a blind spot. A reception area exists beyond the airlock where at times there are staff present with a clear view of who is leaving. These staff appear to plays no roll in monitoring those who are leaving thru the airlock. Consideration should be taken to address the issue of patients tailgating in the airlock and address the closer monitoring of those leaving the building.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the SABP NHS Foundation Trust has the power to take such action.

7	**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.
8	**COPIES** I have sent a copy of this report to the Interested Persons in the Inquest and the Chief Coroner.
9	**Signed:** *Simon Wickens* **DATED this 30th day of January 2015**