REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive, Norfolk and Suffolk NHS Foundation Trust,** **Trust Headquarters,** **Hellesdon Hospital,** **Drayton High road,** **Norwich'** **NR6 5BE.**
1	**CORONER** I am Nigel Parsley, Senior Coroner, for the coroner area of Suffolk.
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.
b	**INVESTIGATION and INQUEST** On 7th April 2017 I commenced an investigation into the death of Matthew Sean Arkle. The investigation concluded at the end of the inquest on 1st November 2018. The conclusion of the inquest was that; Matthew Arkle died as the result of suicide. Matthew was a voluntary patient at the Wedgewood Unit, West Suffolk Hospital who was granted one hours unescorted leave on the 4th April 2017 but did not return. On the morning of 6th April 2017 Matthew was found hanging next to a tree in an area of heath land directly adjacent to the West Suffolk Hospital in Bury St Edmunds. He was pronounced dead at the scene. The medical cause of death was confirmed as: 1(a) Hanging 1(b) 1(c) 2 Schizophrenia and depression.
4	**CIRCUMSTANCES OF THE DEATH** Matthew Arkle was a 37 year-old man with a diagnosis of paranoid schizophrenia. He had been mentally unwell for some time and had a number of admissions to hospital under the Mental Health Act (his first in the year 2000). In December 2016 Matthew took an over dose of prescription medication and was admitted as an inpatient until the 1st February 2017. On the 17th February 2017 he was re-admitted to the Wedgewood Unit, West Suffolk Hospital as an informal patient following a further over dose of prescription medication.

consideration and risk assessment process by the nurse who authorised the unescorted leave.

It was acknowledged that this information may not have changed the decision, but it was deemed to be an important factor to take into consideration.

It was further acknowledged, that due to Matthew's generally compliant nature, had he been asked not to take unescorted leave that day (due to his families concerns) then he may well have remained on the ward of his own choice.

Witnesses on duty on the Northgate ward on the 4th April confirmed that they were unaware of Matthew's family request regarding leave that day. Further, there was no written note of the families request on Matthews case file and no witnesses had any memory of it being verbally raised at the ward handover meeting at the start of the shift.

It was reported that the activity on ward was extremely high on the 4th April 2017. It was heard that although staffing met the required levels, there were a number of patients requiring additional supervision and a high number of 'staff personal alarms' were being activated during the shift. The charge nurse on duty said "I cannot stress enough how busy it was that day" and agreed the ward on the 4th April could be described as being chaotic.

In part, this was held to be the reason that Matthew's time of leaving Northgate ward to go on unescorted leave was originally recorded to be 19.00 with the police subsequently being alerted to his missing person status at 21.06.

CCTV evidence secured from a local garage in the weeks following his death showed that Matthew must have left the ward no later than 17.30 on the evening of the 4th April. It was subsequently identified that the 19.00 timing had been an 'approximation' with it being agreed 17.30 would be a realistic time for Matthew having left the ward.

As such Matthew's unescorted leave should have ended at 18.30 with the alarm being raised for Matthew's absence occurring much earlier than it did. This would have allowed searches undertaken by hospital staff, Matthew's family and the police to commence sooner.

It was confirmed during the hearing that in relation to patients going missing, there is no policy in place for a review CCTV footage available at the Wedgewood Unit or the West Suffolk Hospital to confirm time of leaving, direction of travel, etc. This would have clearly provided an accurate time and possibly direction of travel in Matthew's case.

It was heard that once the Suffolk Constabulary were informed of Matthew's absence they instigated their missing persons protocol designating Matthew as a medium risk on the basis of the information received from staff at the Northgate ward. On the basis of the information the Suffolk Constabulary received this was found to be the appropriate level when reviewing their risk assessment process.

However, Suffolk Constabulary were not told that Matthew had seriously attempted suicide on two occasions in the past three months, were not told that his family had specifically requested he not be granted unescorted leave on the 4th April or that on the previous day Matthew's care coordinator had described him "as the lowest I have seen him for some time." It was heard that there was no set format for the type or nature of the information to be given to the police when a patient goes missing and what information was available in Matthew's case was incomplete (including no recent photograph).

	In evidence it was heard that had the Suffolk Constabulary been given the above information at the time of his going missing that "in all likelihood" Matthew's risk would have been assessed as being 'high'. It was then explained that once a 'high' risk had been declared additional police resources would have become available. This included the immediate deployment of up to 10 police officers to assist in the initial search for Matthew on the night of the 4th April. In relation to the timing of Matthew's unescorted leave it was well documented in his notes that his auditory hallucinations became strongest in the evenings which was often associated with a lowering in his mood. The charge nurse who granted the unescorted leave said that when they did so they could not see any evidence of 'internal stimulation' from auditory hallucination explaining that Matthew did not appear vacant or distracted. However, when coupled to the other identified factors in this case the timing of Matthew's request for unescorted leave was not an identified feature of the risk assessment process prior to his unescorted leave being granted. The jury recorded that the following circumstances may have contributed to Matthew's death:- 1. A failure of appropriate record keeping within Northgate ward. 2. A failure of verbal and written communication within Northgate ward. 3. The general high level of activity and stress on Northgate ward on the 4th April 2017. 4. The delay in noticing, reacting and reporting Matthew as missing. 5. The timing of Matthews release being late afternoon.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you or your organisation 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 8th January 2018. I, the Senior Coroner, may extend the period if I consider it reasonable to do so. 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 Person's. [redacted] and Suffolk Constabulary. I am 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**13th November 2018** **Nigel Parsley**