REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. NHS England; and 2. The Chief Coroner
1	**CORONER** I am Emma Serrano, Assistant Coroner, for the coroner area of the Black Country.
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** 1. On 30/07/2018 I commenced an investigation into the death of David Squire. The investigation concluded at the end of the inquest on the 23/01/19. 2. The conclusion of the inquest was misadventure. 3. The medical cause of death was 1a) Hanging by Ligature
4	**CIRCUMSTANCES OF THE DEATH** 1. On the 25/07/18 David Squire took his own life by hanging himself from a low bridge in Fibbersley Nature Reserve in Willenhall. David Squire was a detained patient having been detained under Section 2 of the Mental Health Act at a care home nearby called The Priory at Lakeside View Care Home. 2. During the course of the inquest evidence was heard as to David Squire's admission to The Priory on the 22/7/18 under Section 2 of the Mental Health Act. This was because he had suicidal thoughts and thoughts of harming others. The Priory was, and still is, a non-smoking hospital in accordance with guidelines set down by NHS England. This states that all hospitals are to be non-smoking. Non-smoking meaning that no smoking is permitted on the premises or grounds of any hospital. The smoking area at The Priory was therefore located outside of the hospital grounds. 3. The Priory offers nicotine replacement to patients that smoke. For patients who refuse and want to smoke a cigarette, permission has to be

	obtained for escorted "off grounds" leave. This is called Section 17 leave. 4. On Tuesday 24/7/2018 David Squire was permitted to have escorted leave off of the grounds of the Priory Lakeside view, for a cigarette. When he had finished his cigarette he refused to come back to The Priory Lakesde View and left. ON the 25/7/18 he was found deceased at in Fibbersley Nature Reserve in Willenhall.
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. Evidence emerged during the inquest which pointed towards two areas of concerns regarding the NHS England Guidance regarding smoke-free hospitals: 1. This guidance does not permit the proper use of Section 17 leave. The Priory is a smoke free hospital in accordance with NHS England guidance and cannot have a smoking area on the hospital grounds. To allow patients to smoke, Section 17 leave is utilised outside of The Priory's grounds. Section 17 leave should be used for many purposes, including patent observation and interaction and to assess whether they are a risk of absconding. Given that purpose, the process of leave is staged. Patients start with escorted leave within the grounds, then unescorted, then escorted leave off grounds and then unescorted. Patients, who refuse nicotine replacement medication, and continue to smoke, must start the staged leave at escorted "off grounds." This is so The Priory can comply with the NHS England guidance. Smoking patents therefore start leave at "off grounds" without the staged process and level of observation that non-smoking patients would be offered. 2. The guidance fails to account for the differing needs regarding the different type of hospital that the policy spans. The application of the guidance to a standard NHS hospital creates far less of a risk than it does to a mental health hospital where it is accepted there is a frequency of patients who are at risk of absconding, self-harm and harm to others. The guidance leaves mental health hospitals, when detained patients smoke and refuse nicotine replacement therapy, to take detained patients off grounds in undesirable circumstances. The guidance, as it stands, with no tool to depart from the guidance, where necessary, leaves a significant risk.
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. You may wish to consider the following: 1. The risk that the policy creates when considering hospitals that deal with patients that are detained under section; 2. Situations where the guidance may be departed from;

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 15 March 2019. 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. The family of David Squire; 2. West Midlands Police; and 3. The Priory at Lakeside View 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	**25 January 2018** **Miss Emma Serrano** **Assistant Coroner** **Black Country Area**