	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Sarah DUGAN, Chief Executive, Worcestershire Health & Care NHS Trust**
1	**CORONER** I am David REID, H.M. Senior Coroner for the coroner area of Worcestershire.
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 [the details below are fictional]** On 25 July 2018 I commenced an investigation into the death of Roy CAMPBELL, then aged 82. The investigation concluded at the end of the inquest on 6 March 2020. The conclusion of the inquest was that Mr. Campbell died from natural causes, the medical cause of death being: 1a Ischaemic and hypertensive heart disease.
4	**CIRCUMSTANCES OF THE DEATH** (1) Roy Campbell was a man who had a significant recent history of cardiac problems and who was living with dementia. By the time of the events with which this inquest was concerned, in July 2018, he was becoming increasingly confused and, on occasions, aggressive and threatening. (2) On the morning of Saturday 21 July 2018, following an incident at his home address, police detained Mr. Campbell under s.136 of the Mental Health Act 1983, and took him to the Elgar Suite at Newtown Hospital, Worcester for a formal assessment. The result of that formal assessment was that Mr. Campbell was detained under s.2 MHA 1983, and admitted to the Athelon ward at the same hospital. Being a detained patient, Mr. Campbell should not have been able to leave the ward unaccompanied. (3) After some 20 minutes on the ward, however, Mr. Campbell was able to leave via an insecure gate which connected Athelon ward's garden with that of the neighbouring ward, Holt ward. Once on Holt ward, Mr. Campbell was able to persuade staff there that he was a visitor, and they let him leave. (4) Athelon ward staff spotted Mr. Campbell making his way across the hospital car park, and were able to approach him as he reached Newtown Road. Mr. Campbell was reluctant to return to Athelon ward, believing that he was on a wartime mission for the Army. With the assistance of some passing ambulance staff, he was eventually accompanied back onto the ward, where almost immediately he went into cardiac arrest. Attempts were made to resuscitate him, and he was taken by ambulance to the Emergency Department of Worcestershire Royal Hospital. Unfortunately he failed to recover, and died there at 1720hrs that day.
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. – (1) During the inquest, I heard evidence from [redacted] who conducted the Trust's own investigation into this incident that, not long after Mr. Campbell's

	death, the Trust had introduced a visitor book system for use in the relevant wards at Newtown Hospital. It was originally thought by the Trust that this system would have been sufficient to prevent patients leaving a ward as Mr. Campbell had done. It was not until evidence was given at the first (aborted) inquest into Mr. Campbell's death in October 2019, however, that the Trust came to the view that this system was inadequate, and further work was carried out which came up with a solution involving the use of an electronic system which will use photographs to identify whether a person who wishes to leave the ward has previously been admitted as a visitor. I am told that, whilst the business case for the proposed new system has been submitted, approval is awaited before it can be implemented. (2) I therefore remain concerned that, unless and until such a system has been approved and put in place, there remains a risk of detained patients absconding from wards at Newtown Hospital and, if elderly and/or physically compromised as Mr. Campbell was, an increased risk of death in any such patient. (3) During the inquest I also heard evidence that environmental checks, introduced by Athelon ward to try to identify and remedy any means by which a determined patient could try to leave the secure confines of the ward, were not being carried out properly at the time of these events, and are still not enshrined in Trust policy, thereby ensuring staff receive mandatory training on it. I was concerned to be told that, only after evidence in this inquest was heard on Monday 2 March 2020, the current form being used to record such checks was revised and staff on both Athelon and Holt wards were instructed to start using it. I was surprised that these revisions were made at such a late stage, when the information given in evidence which led to those revisions must have been available to the Trust some time ago. I am also informed that it would take at least a further 2 months for the proper completion of this form to be enshrined into Trust policy. (4) I am concerned that, unless and until these environmental checks become the subject both of Trust policy and of mandatory training for all ward staff, there remains a risk that the means by which a vulnerable patient might try to leave the confines of a ward may not be identified in time. If that patient were to be elderly and/or physically compromised, as Mr. Campbell was, this will lead to an increased risk of death in any such patient.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 4 May 2020. 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) [redacted] solicitors, who act for Mr Campbell's family; (2) [redacted] solicitors, who act for Worcestershire County Council, the employers of [redacted] who was the Approved Mental Health Practitioner who coordinated Mr. Campbell's admission to Athelon ward on 21.7.18. 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	**9 March 2020**	**Signed:**