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

The Inquest Touching the Death of Kimberley Smith
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive Surrey and Borders Partnership NHS Foundation Trust Third Floor Leatherhead House Station Road Leatherhead Surrey KT22 7FG
2	**CORONER** Miss Anna Crawford, HM Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
4	**INQUEST** The inquest into the death of **Kimberley Smith** was opened on 19 March 2019. It was resumed on 9 November 2020 with a jury and concluded on 20 November 2020. The medical cause of Miss Smith's death was: 1a. Plastic Bag Asphyxia The inquest concluded with a short form conclusion of suicide and a narrative conclusion which is set out below.

5	**CIRCUMSTANCES OF THE DEATH** Kimberley Smith had been diagnosed with Depression, Anorexia Nervosa, Post-Traumatic Stress Disorder and Emotional Unstable Personality Disorder and had a history of alcohol dependency and self-harm. On 20th September 2018, 29 September 2018 and 2 October 2018 she was admitted to hospital following attempts to take her own life whilst under the influence of alcohol. On 3 October 2018 Miss Smith was assessed under the Mental Health Act and admitted as an informal patient to the Abraham Cowley Unit (ACU), which is an inpatient psychiatric unit run by Surrey and Borders Partnership NHS Foundation Trust (SABP) on the site of St. Peter's Hospital. Following her admission she was begun on alcohol detoxification treatment and was assessed as being at high risk of suicide and/or self harm whilst intoxicated. On 5th October 2018 Miss Smith absconded from the ACU whilst out on unescorted leave and was taken to A&E at St. Peter's Hospital by a member of the public before being returned to the ACU in a highly intoxicated state. On 6 October 2018 she was placed on a short-term section which was subsequently allowed to lapse on 9 October 2018. On 10th October 2018 she again absconded from the ACU following a period of escorted leave. She was returned to the ACU by a new acquaintance in the early hours of the 11th October 2018, again in a highly intoxicated state. On 12th October 2018 she left the ACU for several short periods of unescorted leave and returned as expected. She was then moved from 15 minute to hourly observations. At 15:20 she was signed out on unescorted leave and was expected back at 16.30 but she did not return. At approximately 19:30 and 22:30 on 12 October 2019 an acquaintance of Miss Smith's called the ACU to say that she was intoxicated and that he was concerned about her. At 00.05 on 13th October2018, Kimberley Smith was returned to the car park of the Abraham Cowley Unit by the same acquaintance. However, she absconded before going back in to the unit

	and the acquaintance handed over Miss Smith's bag to ACU staff which contained bottles of alcohol, over the counter medication, razor blades and string. At 00:10 on 13 October 2018 the ACU staff called the police and reported Miss Smith as missing and a missing person's investigation was commenced. At approximately 14:00 on 13 October 2018 two female patients of the ACU saw and spoke to Miss Smith in a wooded area adjacent to the unit shortly before 14:00 and agreed to return there later that afternoon to see her. At approximately 16:45 the same patients returned to the wooded area and found Miss Smith with a plastic bag over her head tied with string. Emergency services were called to the scene and paramedics declared Miss Smith deceased at 17:04 on the 13th October 2018. The jury's narrative conclusion is set out below: The following made a material contribution to Kimberley Smith's death: • The care planning and risk management in relation to Kimberley Smith's use of alcohol and the risks she posed to herself if she left the ward and consumed alcohol were inadequate. • The failure to assess and detain Kimberley Smith under the Mental Health Act on either the 8th or 11th October 2018. • The decision to allow Kimberley Smith to leave the unit on unescorted leave from 11th October 2018. • The nursing staff on duty on the Abraham Cowley Unit on 12th October 2018 did not have sufficient knowledge and understanding of Kimberley Smith's recent history, alcohol dependency and risk. • The failure of nursing staff to carry out an adequate risk assessment prior to the decision to allow Kimberley Smith to leave the Abraham Cowley Unit at 15:20 on 12th October2018. • The failure of the staff on duty on the Abraham Cowley Unit on the day shift to activate the missing person protocol on 12th October 2018 before the end of their shift. • The failure of the staff on duty on the Abraham Cowley Unit on the night shift to activate the missing person protocol on 12th October 2018 following a telephone call to the ward at approximately 19.30. The following possibly made a material contribution to Kimberley Smith's death:

	• The decision to reduce the level of observations on Kimberley Smith from every 15 minutes to hourly on 12th October 2018. • A failure by the staff on duty on the Abraham Cowley Unit on 13th October 2018 to make fellow patients aware that Kimberley Smith had not returned to the ward since the previous day. • The information available and provided to the police by the Abraham Cowley Unit nursing staff when she was reported missing on 13th October 2018, including the lack of a completed Missing Persons Pack, was inadequate. • The recording of the information on the Computer Aided Dispatch (ICAD) that was obtained during a phone call from Surrey Police at 01.00 on 13th October 2018 with a witness, was inadequate. • The absence of any warning markers on the Police National Computer or the Surrey Police System NICHE with regards to three recent incidents which had resulted in Kimberley Smith being detained by the police under s.136 of the Mental Health Act. Kimberley Smith's death was contributed to by Neglect.

6	**CORONER'S CONCERNS** The Coroner's concerns are as follows: During the inquest the court heard evidence regarding the policies and procedures in place governing requests by informal patients to leave the ACU. The Coroner heard evidence, and accepts, that this is a complex issue in that informal patients are entitled to their liberty whilst at the same time potentially presenting a risk of harming themselves. The Coroner is concerned – particularly given the complexity of this issue – that there is no written policy or guidance on it aside from a short paragraph within the Trust's policy governing leave for detained patients. In particular, there appears to be no clear written policy/procedure on the following: - The carrying out of risk assessments when informal patients request to leave the unit; - The relevance of an informal patient being on intermittent observations when they request to leave the unit; - The processes to follow if informal patients are risk assessed as too high risk to leave the unit; - The risk management plans to put in place when informal patients do leave the unit; - The recording of assessments and decisions relation to requests made by informal patients to leave the unit; - The timeframe for reporting informal patients to the police as missing persons if they fail to return at the agreed time. Whilst the inquest into Miss Smith's death was concerned with the policies in place for informal patients, the Coroner is not aware of a clear timeframe for reporting detained patients either and consideration should be given to introducing a clear timeframe for detained patients as well. Consideration should also be given to ensuring that all staff are fully trained and competent in any new policies and/or procedures introduced in relation to the matters set out above.

During the course of the inquest the court also heard that following Miss Smith's death SABP carried out a Serious Incident investigation which resulted in the following recommendation,

'To develop a protocol for managing alcohol detoxification on mental health wards, including specific care plans, minimum monitoring and how to manage leave requests during treatment.'

The court heard that a protocol has been developed to manage the medical aspects of alcohol detoxification but does not cover care plans, minimum monitoring or the management of leave request during treatment.

It is of concern that these aspects of the recommendation remain outstanding and consideration should be given to implementing them as a matter of urgency.

The **MATTER OF CONCERN** is:

1. There is no clear written policy/procedure on the following:

- The carrying out of risk assessments when informal patients request to leave the unit;
- The relevance of an informal patient being on intermittent observations when they request to leave the unit;
- The processes to follow if informal patients are risk assessed as too high risk to themselves to leave the unit;
- The risk management plans to put in place when informal patients do leave the unit;
- The recording of assessments and decisions relation to requests made by informal patients to leave the unit;
- The timeframe for reporting informal patients to the police as missing persons if they fail to return at the agreed time.

2. There is no clear written policy/procedure on the following:

- The timeframe for reporting detained patients to the police as missing persons if they fail to return at the agreed time.

3. Consideration should be given to introducing written policies in relation to the above matters and to ensuring that all staff are fully trained and competent in relation to these matters.

	4. Consideration should be given to implementing the recommendation arising from the Serious Incident investigation to develop a protocol for managing alcohol detoxification on mental health wards, including specific care plans, minimum monitoring and how to manage leave requests during treatment.
7	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
8	**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.

9	**COPIES** I have sent a copy of this report to the following: 1. Chief Coroner 2. Miss Smith's family 3. Chief Constable of Surrey Police 4. Independent Office for Police Conduct
10	**Signed:** **Anna Crawford** **H.M Assistant Coroner for Surrey** **Dated this 9th day of December 2020**