	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Midlands Partnership NHS Foundation Trust
1	**CORONER** I am Mrs Joanne Lees, Assistant Coroner, for the coroner area of Shropshire, Telford & Wrekin
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** On 19/6/19 I commenced an investigation into the death of Lee William Davies who died on the 18th June 2019 at Worcester Royal Hospital. The investigation concluded at the end of the inquest before a Jury on 8/10/20 The conclusion of the Jury was a narrative conclusion. The Jury made the following findings of fact; **On the evening of 17 June 2019 Mr Lee Davies who was detained under S3 MHA, absconded from the Laurel Ward in the Redwoods Centre in Shrewsbury where he was receiving treatment for his mental health condition. Lee was at high risk of absconding and had previously absconded twice. Both times he had used drugs during his absence. His observations had been reduced that morning. He went missing from the ward between 8-9 pm. It is probable he scaled a fence in the ward garden. Lee was reported to the police by staff as a missing person. Lee was not located until the following day when an ambulance was called to an address in Church Stretton where Lee was found unconscious and taken to Royal Worcester Hospital where illicit drugs were found in his urine test. He passed away later that day.** The Jury's narrative conclusion was as follows; **Mr Davies died from a brain injury caused by the use of illicit drugs. Lee's risk of absconding to obtain drugs was not adequately considered when deciding to reduce his observation levels on the morning of 17/6/19. This did not affect the outcome.**
4	**CIRCUMSTANCES OF THE DEATH** Lee Davies was a detained patient under s 3 MHA. He had absconded from Laurel Ward at the Redwoods Centre, Shrewsbury on the evening of 17/6/19. He was found the following day at an address in Shrewsbury unconscious and taken to Worcester Royal Hospital by air ambulance following an out of hospital cardiac arrest. The working diagnosis for the cause of the cardiac arrest was aspiration pneumonia secondary to possible illicit drug use. He had a CT scan of his brain which confirmed a hypoxic brain injury. Urine toxicology tests on admission were positive for opiates, heroin, cocaine, benzodiazepines, quetiapine and promethazine. He died in hospital on 18/6/19 after treatment was withdrawn. Mr Davies had significant mental health issues and drug addiction problems and had previously absconded from the hospital twice to use illicit drugs.

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 course of the inquest I heard evidence that it was likely that Mr Davies had absconded on 17/6/19 by scaling a perimeter fence in the garden of Laurel Ward. The Jury was told that patients had unrestricted access to the garden except when the doors were locked overnight between 10.30 pm – 7.30 am; (2) The inquest heard that on 5/6/19 Mr Davies attempted to climb over the fence with a chair; (3) Mr Davies had absconded from Laurel Ward on 2 occasions since he was detained under s3 MHA on 24/5/19 and on 15/6/19 and used drugs. On the latter occasion he was reported by a peer to have climbed over the fence. *(4)* On 16/6/19 Mr Davies attempted to abscond again by trying to climb over the fence and was stopped by staff. He was observed to be arranging items to help him climb over the fence namely a bin and a chair. *(5)* The deceased was admitted to the Centre with a known substance abuse problem; *(6)* The jury was told by the Responsible Clinician that the deceased was also at risk of obtaining drugs from within the ward itself as the ward was not secure; *(7)* I also received evidence during the investigation that when Mr Davies's personal belongings were collected following his death, these included a crushed metal can likely to have been used for narcotic use; *(8)* The inquest heard evidence that the fence of Laurel Ward garden was approximately 3100 mm in height having been increased in 2015. *(9)* The inquest was provided with two photographs of the fence taken on the morning of the third day of inquest being 8/10/20 that showed a wooden panelled fence with a metal mesh/wire upper level behind a paved pathway with a shrubbery filled with green foliage and plants; *(10)* The photographs showed that some of the shrubbery plants were almost as high as the wooden part of the fence and very dense to the extent the fence could not be seen behind them and nor could the ground beneath due to ground level foliage; (11) I heard evidence at the conclusion of the inquest in the absence of the Jury that the shrubbery was not considered to be dense enough by the head of security to conceal any items and that after an incidents of absconding a anti climb review was undertaken; (12) My concern is that it is not sufficient to carry out a search of the area after a patient has absconded. The current planting arrangements based on the most recent photographs, do appear to provide ample ground coverage for ANY item to be concealed including drugs, drug paraphernalia, weapons, items that could be used as weapons and items in connection with absconding. (13) There was no evidence that the garden was searched on a regular basis, patients were not observed in the garden unless their level of observation included eyesight observations, and there was no CCTV covering the garden area. (14) My view is that circumstances of the current planting arrangements in the shrubbery present a risk of deaths which will continue to exist. This also extends to a risk of injury to staff on Laurel Ward and other patients.
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation have the power to take such action. The Trust may wish to consider removing the plants/foliage and/or introducing regular searches of the garden and shrubbery area.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 30/11/20. 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, Mrs [redacted], mother of the deceased. I have also sent a copy of my report to the CQC. 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	 **Mrs Joanne M. Lees** **Assistant Coroner** **Shropshire, Telford & Wrekin** **9/10/20**