# CORONER'S OFFICE
## DISTRICT OF HERTFORDSHIRE

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**MR EDWARD THOMAS** Senior Coroner **GRAHAM DANBURY** Deputy Coroner
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Assistant Coroners


8 October 2015

The Rt Hon Jeremy Hunt MP
Secretary of State for Health
Department of Health
79 Whitehall
London
SW1A 2NS

Your Ref: to be advised
Our Ref: 02049-2013

Dear Mr Hunt,

**Re: Rebecca Emily JONES, deceased**

I am writing to you under the provisions of Schedule 5 (paragraph 7) of the Coroners & Justice Act 2009 which came into force in July 2013. This re-enacted the provisions of the old Rule 43 of the Coroners Rules 1984. Attached to this letter is information concerning the new rules and regulations from which you will see requires a written response. Copies of this letter and the response received from you will be forwarded to the other interested persons identified at the inquest in accordance with the list attached. I am also sending a copy of this letter to the Department of Health for their general information.

Please find enclosed a copy of the Record of Inquest from which you will note that the jury's findings in respect of a number of matters. Becky (a name she was always known by) was known to mental health services since she was an adolescent and had a number of admissions to hospital under detention and also the use of Section 136. On the 22nd August 2013 she was found near a railway line in a confused state and acting in a way that was dangerous to herself. Police detained Becky under Section 136 and brought her to the 136 Suite at the Lister Hospital, Stevenage; a facility that had been used for a number of years. I heard evidence from the Head of Public Protection at Hertfordshire Constabulary, Detective Superintendent Hanlon, that there had been no use of police cells in the purposes of Section 136 for a number of years. It is clear that police cells should only be used as a very last resort in matters like this, but it is therefore incumbent upon those providing the 136 facilities should ensure that they provide a safe containment pending the assessment that must take place within a reasonable period of time.

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Becky was brought into the Section 136 Suite just after midnight on the 23rd August 2015. In accordance with their protocol (which was accepted by the jury as reasonable) police officers left the unit following a joint assessment with the bleep holder as it was deemed that Becky posed a Low Risk for the purpose of containment within the Section 136 Suite. She presented no management problem, was compliant and placid and was not wanted on the police national computer. Thereafter the assessment under Section 136 was not able to be carried out within the three hours expected in accordance with the joint protocol, because an urgent assessment was required for two other vulnerable persons with learning difficulties in the community who were threatening self-harm. As Becky was "in a place of safety" it was felt that the community assessments had to take priority. However, the jury found during evidence that there was inadequate supervision of Becky, who was last seen at about 04:00 then discovered to be missing when the assessing team came to interview her at 05:30. Becky was found dead at about 09:00 later that morning in the open on ground below as service ramp near the mortuary entrance at the Lister Hospital. Cause of death was multiple traumatic injuries, to her head as she had fallen from a height.

The window of the 136 Suite had been left open for ventilation and although there were restrictors the window was replaced quickly to a fixed non opening window. There was no CCTV camera surrounding the 136 room but one has now been installed so that images can be viewed by the mental health reception staff and staff covering the Aston Ward. The CCTV also covers the corridor leading to and from the 136 Suite. Emergency door releases on the 136 room and on the rear corridor of the ground floor of the mental health unit, both operated by push buttons were also replaced by key operated door release, and all windows in the mental health unit are to be fitted with restrictors. The windows in the toilets and baby changing area on the 136 corridor had window mesh fittings added to the fanlight opening.

The window in the 136 Suite room was at ground floor level and during the inquest our attention was drawn to an Estates and Facilities Alert from the Department of Health under reference EFA-2013-002 issued 23 January 2013. This indicated that window restrictors may be inadequate in preventing a determined effort to force a window open beyond the 100mm restriction. We were given to understand that this primarily aimed at preventing falls through windows from a height, but it should equally apply to spaces where ventilation was needed in rooms containing vulnerable people, irrespective of floor height, to prevent them leaving via the window.

I am drawing your attention to these changes that have been made as it may well be that other Section 136 Suites, particularly those that have been of longstanding use may not be designed or equipped in such a way to prevent a person in a place of safety from absconding.

The jury found that the major contribution in Becky's absconding was the absence of continuous observation.

We also heard evidence regarding bleep holder training. Although it was clear that some training was given, the Hertfordshire Partnership University NHS Foundation Trust has decided to operate a more focused training programme for bleep holders especially as it is also now apparent that the use of Section 136 has increased dramatically over the last year. I heard evidence that the S136 had been used over 500 times in the year up to April 2015. An examination of bleep holder training offered by other Trusts may well be appropriate.

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Becky was a student at Sheffield University and came back to Hertfordshire after a stay being an in-patient in a psychiatric unit in Sheffield. She was brought down by the discharge nurse with a discharge summary in July but unfortunately there was no care programme meeting arranged for the continuation in relation to her care. In addition, perhaps in accordance with Becky's preference, her care coordinator was her psychiatrist with whom she appears to have had a good relationship. However, it was agreed that it might have been more appropriate for her to have had a care coordinator from another professional from the team as the psychiatrist was sadly not kept informed in relation to assessments that were taking place after she presented in an Accident and Emergency Department following overdoses or thoughts of self-harm.

The importance of good communication for patients who are being transferred to other areas and within a team, ensures that any worrying signs can be noticed leading to support and action as required. Although this maybe not a critical factor in relation to this tragic death, I thought I would draw this to your attention for encouragement for other mental health trusts of better communication between and amongst themselves.

The Hertfordshire Partnership Trust has now arranged for spot checks to be carried out by senior staff by walking through such units and seeing what is going on. This seems to be a very good practice that I feel other Trusts may wish to consider.

The schedule requires a response from you within 56 days of receipt which I calculate is the 3rd December 2015. Please let me know if there are difficulties in complying with this timescale. I am retiring as Senior Coroner on the 31st October 2015 but I have discussed this report with my successor, Mr Geoffrey Sullivan.

Yours sincerely

Edward G Thomas
Senior Coroner