Leeds and York Partnership NHS
NHS Foundation Trust

Date: 08th December 2021

[redacted]

Leeds and York Partnership NHS Foundation Trust
2150 Century Way
Thorpe Park
Leeds
LS15 8ZB

Mr Kevin McLoughlin
Senior Coroner, Western Yorkshire (Eastern District)
Coroner's Office and Court
71 Northgate
Wakefield
WF1 3BS

Dear Mr McLoughlin,

RE: REGULATION 28 REPORT TO PREVENT FUTURE DEATHS: Alexandra Jane TOLLEY, (deceased)

Thank you for the correspondence regarding the outcome of the inquest, which was concluded on 13 October 2021, touching upon the death of Ms Alexandra Jane Tolley. I would firstly like to take this opportunity to express my sincere condolences to Alexandra's family and friends at the tragic death of Alexandra.

Following the Regulation 28 Report to Prevent Future Deaths issued on the 14 October 2021 to Leeds and York Partnership NHS Foundation Trust (LYPFT), please find below the details of our response to address the concerns raised.

The Matters of Concern within the report have been broken into the points below in bold text with the Trust's response following:

1. **The Care Plan agreed between Ms Tolley and the team treating her, included a provision that in the event she absconded, she would neither be restrained, nor followed. Given her history and risk profile, it appeared this contingent instruction to staff regarding the risk of absconding, placed too much emphasis on her long-term ability to manage her own turbulent emotions, at the expense of the imperative of keeping her safe. The priorities underlying such instructions merit further review.**

One of the challenges of caring for patients with a diagnosis of Emotionally Unstable Personality Disorder (EUPD) as Ms Tolley, is that there are often times that being able to articulate distress in a verbal way is difficult, and therefore a way to describe this is often through self-harming behaviour, which was the case for Ms Tolley.

In the case of Ms Tolley staff were trying, by building a therapeutic relationship, to balance a positive risk-taking approach by not being over restrictive but applying restriction at the right time in the right way to support Ms Tolley.

A comprehensive care plan had been established that described the management of risks associated with Ms Tolley's self-harm behaviour at times of distress. Unfortunately, what is not described is the staff's ability to increase or decrease the least restrictive care in line with any observed changes to Ms Tolley's presentation.

In order to ensure the Trust has learnt lessons from Ms Tolley's death, it is vital that team and clinical services review interventions described within care plans and leave agreements and consider how these interventions can be altered depending on an individual's presentation at a moment in time or following any change in the baseline mental state or any significant events. This will allow staff to use a more collaborative approach of engagement to enable them to respond to risk and also balance the risk associated with needing to potentially intervene when leave is in progress.

Where any leave is agreed, the balance of any associated risk should be weighed up prior to the leave and documented, to enable it to commence or be suspended for a period. Within that any consideration to leave boundaries should also be considered, for example, is it appropriate to place hands on a patient if the need arises in order to maintain their safety.

To support this learning, the following work will be undertaken through the local clinical governance forums and monitored through audit.

- Staff are to reflect upon this case and subsequent learning. Teams will also liaise with colleagues in the EMERGE Leeds (previously known as the Personality Disorder Manged Clinical Network) to consider what further support they can provide to our inpatient staff. This will be seen as an outside voice that can provide a reflective space with expertise.

2. **The absconding instructions to staff (set out above) seems incompatible with the duty to detain in order to keep safe, inherent in an order under Section 2 of the Mental Health Act 1983 when viewed in the context of a patient deemed to require such intensive monitoring.**

The Trust has reviewed its Prevention, Management of Violence and Aggression (PMVA) training provision offered to staff regarding the role of escorting patients outside of the ward and is developing training for all staff, including bank staff. This training will be included in the initial and updated PMVA training provision. The training will be scenario and role play based and will include discussions regarding decision making related to risk whilst escorting somebody outside of the ward.

This face-to-face group scenario will allow for wider discussion on the legal and ethical principles in relation to managing difficult decision making alone which may result in the use of force being required to return someone from leave.

This training aims to equip all staff with the knowledge and confidence to be able to act quickly and autonomously in challenging clinical situations. The PMVA team will be supported and supervised by the Trusts subject matter experts to ensure this is implemented effectively.

3. **The decision to permit ground leave so shortly after a [redacted] incident (and only three days after a previous absconding incident) was made on a relatively informal basis. There were no documented criteria to be considered before it was approved, nor was the grade of staff required to make the decision stipulated.**

Consideration for leave from the hospital ward are discussed via the Multidisciplinary Team (MDT). It is at this meeting that the type of leave is discussed and agreed upon and this decision is based on risk, current presentation, and history in relation to what is appropriate and therapeutic for the patient at that time.

Despite a patient being granted ground leave, a further assessment should be undertaken on the day taking into consideration a number of factors including compliance with previous leave, consideration of benefits of further leave, and flexibility versus senior guidance. Additionally, the following points should be taken into consideration:

- Any periods of recent changes to mental state and presentation
- Review of risks associated with leave which may or may not impact on the current requested leave
- Review success of previous leave

Following this review a decision will be made in conjunction with the registered/named nurse along with the nurse in charge (if required) to consider the appropriateness of leave and if this should be altered. Staff must ensure that the decisions as detailed above are documented within care records including the rationale and wider discussion.

4. **The instruction to staff stipulated 'physical interventions' will not be used to restrain Ms Tolley, yet this expression was not defined or particularised. Greater clarity might assist a staff escort (likely to be a relatively junior individual) to know whether it was permissible, for example, to put a gentle hand on Ms Tolley's shoulder to steer her back towards the hospital.**

The care plan developed by the team and Ms Tolley considered the intervention of placing any form of touch to Ms Tolley. It was deemed this would increase the risk of further distress to Ms Tolley and may further increase the risk of emotional deregulation in the event of an individual placing a hand on her. However more consideration should have been given to the need to think about alternative means to support Ms Tolley, enabling her to maintain her self-control at the point of feeling distressed whilst out on leave. Alternative strategies that could have been considered at the point Ms Tolley indicated either physically or verbally that she was becoming distressed or that she was not coping with the period of escorted leave.

In keeping with the Trusts review of its Prevention, Management of Violence and Aggression (PMVA) training provision, as referred to in the previous response, training will be offered to staff regarding the role of escorting service users outside of the ward and is developing training for all staff, including bank staff. This training will be included in the initial and updated PMVA training provision. The training will be scenario and role play based and will include discussions regarding decision making related to risk whilst escorting somebody outside of the ward.

This face-to-face group scenario will allow for wider discussion on the legal and ethical principles in relation to managing difficult decision making alone which may result in the use of force being required to return someone from leave.

This training will equip all staff with the knowledge and confidence to be able to act quickly and autonomously in challenging clinical situations. The PMVA team will be supported and supervised by the Trusts subject matter experts to ensure this is implemented effectively**.**

5. **The permission given to walk in the grounds of the hospital was not considered to amount to section 17 MHA 1983 leave. The informality involved in the decision missed an opportunity to consider issues such as: (a) Whether two escorts would be appropriate in view of Ms Tolley having absconded three days earlier. This would have facilitated one person following her to monitor and report on her whereabouts. In a time, critical situation this could have altered the tragic outcome; (b) Providing the escort with a discretion in the manner of a dynamic risk assessment whether or not to follow Ms Tolley. (c) Reviewing the type of bandage applied to her wounds, before she was permitted to leave the ward, in the light of her** [redacted]

Consideration for leave from the hospital ward is discussed via the MDT, it is at this meeting that the type of leave is discussed and agreed upon. This decision is based on risk, current presentation, and history in relation to what is appropriate and therapeutic for the patient at that time. The same principles would occur when discussing whether section 17 leave is appropriate. It was considered by the MDT that Ms Tolley was suitable for periods of leave within the hospital grounds as a first step on her recovery. Although ground leave had been granted by the Registered Clinician, there is an expectation that the nursing staff will dynamically review risk prior to letting a patient off the Ward. It is at this point that a review can be made, and further consideration should be given in relation to the care plan and any further interventions that may be required whilst out on leave i.e., increase in escorts.

To reflect and understand this further the Trust is going to undertake a tabletop review, which will look at a sample of patients who have been given time off the ward to ensure the discussions as described above have taken place and appropriately documented within the patients care record.

We acknowledge that Ms Tolley had previously [redacted]. The ward team considered this along with the risk that her wound would become infected. The team have identified that they could have requested guidance and support from the Trusts Physical Health Team to support them in considering the prevention of infection and the types of wound coverage that could have been used as alternative.

6. **The care plan containing the staff instruction not to restrain, or follow was discussed and agreed with Ms Tolley. She was thus expressly aware that if she did decide to abscond, she knew she would be able to do so. Moreover, she was explicitly told that the staff member escorting her would return to the reception area and wait for a short period in the hope Ms Tolley would return voluntarily. The implication of this was that Ms Tolley knew she had a period of grace of around 10 minutes in which to get clear of the hospital, before the police would be asked to search for her. Whilst potentially beneficial from a therapeutic perspective, such knowledge may also inform a**

vulnerable patient on ways in which the protection afforded by an MHA Section could be undermined. The wisdom of explaining to a patient how the hospital staff would respond to them absconding should be reviewed.

The Trust identifies that it is good practice to work collaboratively with service users in all aspects of their care. It is important to build a relationship with open and honest conversations with our service users to ensure there is clarity and mutually agreed expectations about actions that will be taken in response to incidents such as absconsions. There is a recognition that as Ms Tolley was aware that a short period of time would be given for her to return to the site, and that rather than this aid Ms Tolley's positive decision making as intended and planned for, she utilised the time to take herself away from the Ward before the Police were notified. We will ensure that the learning from this case is communicated within our procedure – ensure that staff are provided with clear guidance when escorting patients of the action to be taken should leave start to break down or the patient leaves the member of staff.

7. **Ms Tolley was found with a [redacted] used some time earlier to dress a self-inflicted wound. She had twice before used such [redacted]: (1) earlier the same day and (2) three days previously- 24 October. Consideration should be given to the types of wound [redacted] used at the Becklin Centre, with a view to selecting a type which could not serve as a [redacted].**

We acknowledge that Ms Tolley had previously used her [redacted]. The ward team considered this along with the risk that her wound would become infected. Further learning is that the Ward Team could have requested guidance and support from the Trusts Physical Health Team to support them in considering the prevention of infection and the types of bandages that could have been used as alternative.

We acknowledge that the sourcing of equally effective bandage material is sensible, our Physical Health Team have been requested to scope what other [redacted] options are available. As part of this work, they will also contact other Mental Health Trusts to ensure that any good practice is captured and/or shared.

Our [redacted] Anchor Point Assessment Procedure highlights bandages within our guidance for staff on [redacted]. We will reference this when we share the report for learning with our clinical teams through our governance structures.

8. **The Inquest was informed that the general policy in relation to absconding patients has been under review since Ms Tolley's death nearly two years ago but has (understandably) been delayed during the Covid pandemic. It was said a draft revised policy was sent to West Yorkshire Police on 14 June 2021 by way of consultation, but no response has been received. In the meantime, similar instructions are still being issued to staff not to restrain or follow in some other cases. There is thus an ongoing risk of further deaths should a comparable situation arise again.**

The Missing Service User Procedure, although led by the Trust, is jointly agreed with West Yorkshire Police. Feedback on the procedure was received from West Yorkshire Police on the 11 November 2021. Upon receipt of the regulation 28, both organisations have taken a further review of the procedure to ensure it contains the learning from the death of Ms Tolley. We are currently

reviewing this feedback to ensure that it also meets the Trust's requirements for a procedure that is accessible and easily understandable for our staff.

The draft procedure will be circulated to stakeholders for comment on the week commencing the 13 December 2021 and will then be ratified and circulated by January 2022. The updated procedure will be disseminated to all staff via Trustwide email, and any required adjustments will also be made to any associated training.

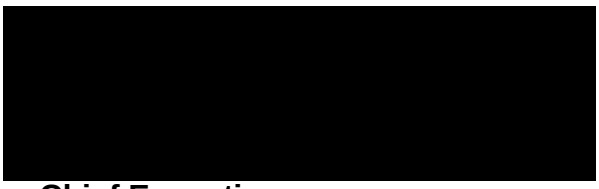
We recognise that the time taken to progress this procedure is not acceptable, to ensure this does not occur in any future policies developed in collaboration with outside organisations we will communicate the following information through our governance structures:

Where outside organisations' input is sought for a procedure, the report author must ensure that the outside organisations are given clear timescales to provide their input and in the absence of any input the Trust will proceed to revise its procedure and progress with implementation.

I hope that this response provides assurance of improvement, consistent with the concerns highlighted in the Regulation 28 and we thank you for the opportunity to further reflect on the learning following the sad death of Ms Tolley.

To support the further learning that will take place, the Trust will be developing an action plan which will include all the recommendations provided within this response, we will of course share this with you. We would be pleased to provide any further information or clarification required. If you feel that a meeting with staff to discuss any of the above would be helpful, please do contact us.

Yours Sincerely



Chief Executive