## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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| | **THIS REPORT IS BEING SENT TO:**<br><br>**Leeds and York Partnership NHS Foundation Trust** |
| 1 | **CORONER**<br><br>I am Kevin McLoughlin, Senior Coroner for the Coroner area of West Yorkshire (East) |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 29 October 2019 an investigation was commenced into the death of Alexandra Jane Tolley, aged 20. The investigation concluded at the end of the Inquest on 13 October 2021.<br><br>The jury returned a narrative conclusion based upon their finding that Ms Tolley committed suicide. This reflected the cause of death:<br>1a Hypoxic brain injury<br>[redacted] |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Ms Tolley, aged 20, was compulsorily detained in a psychiatric hospital under Section 2 of the Mental Health Act 1983, on 24 October 2019. She had a long history of self harming and [redacted] incidents. She was subject to continuous 1:1 observations within eyesight and was not allowed bathroom privacy.<br><br>On Sunday 27 October 2019, after a [redacted] incident in the [redacted] at lunchtime, she was permitted to walk in the hospital grounds, accompanied by an escort.<br><br>At 13:50hr she absconded. This was reported to the police at 14:10hr and classified as a high risk missing person. At 14:46 hr she was found by police officers in cardiac arrest with a [redacted]. [redacted]. Despite emergency treatment Ms Tolley was declared dead on Monday 28 October 2019 at St James' University Hospital, Leeds. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>Evidence taken at the Inquest indicated Ms Tolley had been admitted to the Becklin Centre late on the night of 18 October 2019 and was Sectioned on 24 October. She was categorised as at 'high risk' and deemed to require 1:1 continuous observations, within eyesight, without bathroom privacy. In the days preceding her death 7 [redacted] incidents occurred, culminating in one around 13.00 hours on Sunday 27 October. At approximately 13.50 hours the same afternoon she absconded whilst being permitted to walk in the hospital grounds with an escort. Approximately one hour later she was found with a [redacted] that resulted in un-survivable injuries and died the following day. |

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.

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.

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.

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.

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 [redacted] applied to her wounds, before she was permitted to leave the ward, in the light of her misuse of these [redacted].

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 a MHA Section could be undermined. The wisdom of explaining to a patient how the hospital staff would respond to them absconding should be reviewed.

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

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.

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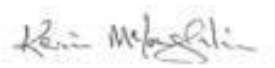
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 10 December 2021. I, the Coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:<br><br>[redacted]<br><br>I have also sent it to West Yorkshire Police (FAO Inspector [redacted]) who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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.<br><br>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 | **SIGNED BY SENIOR CORONER, KEVIN MCLOUGHLIN**<br><br>  <br><br>**14 October 2021** |